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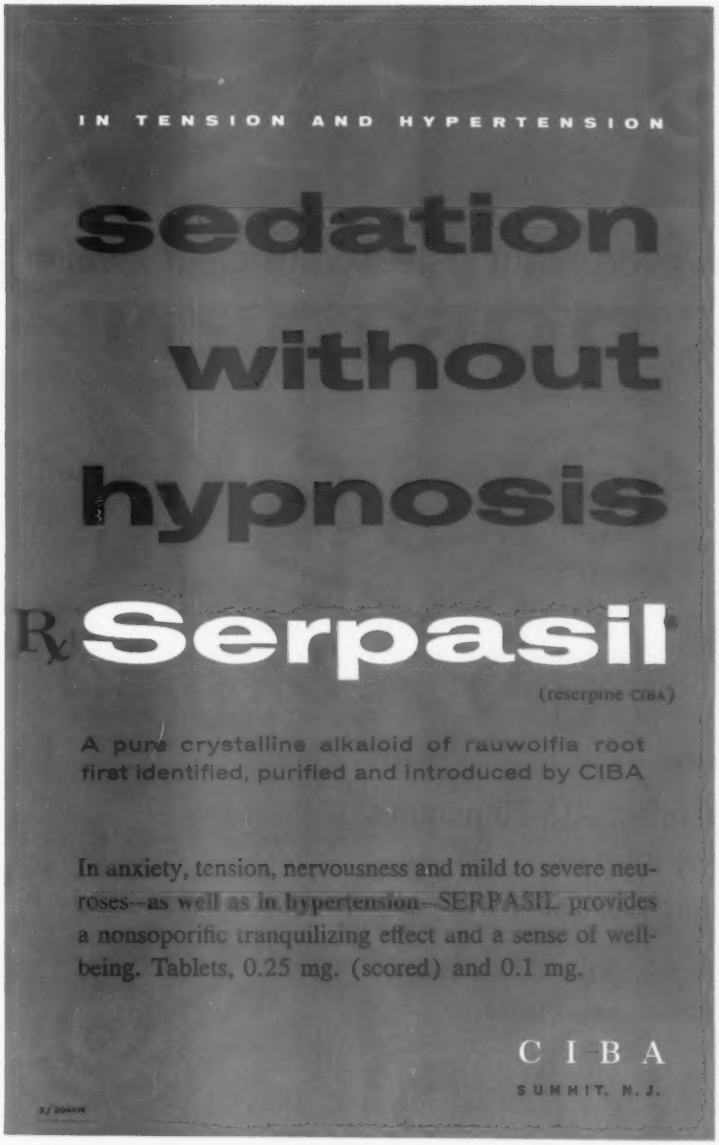
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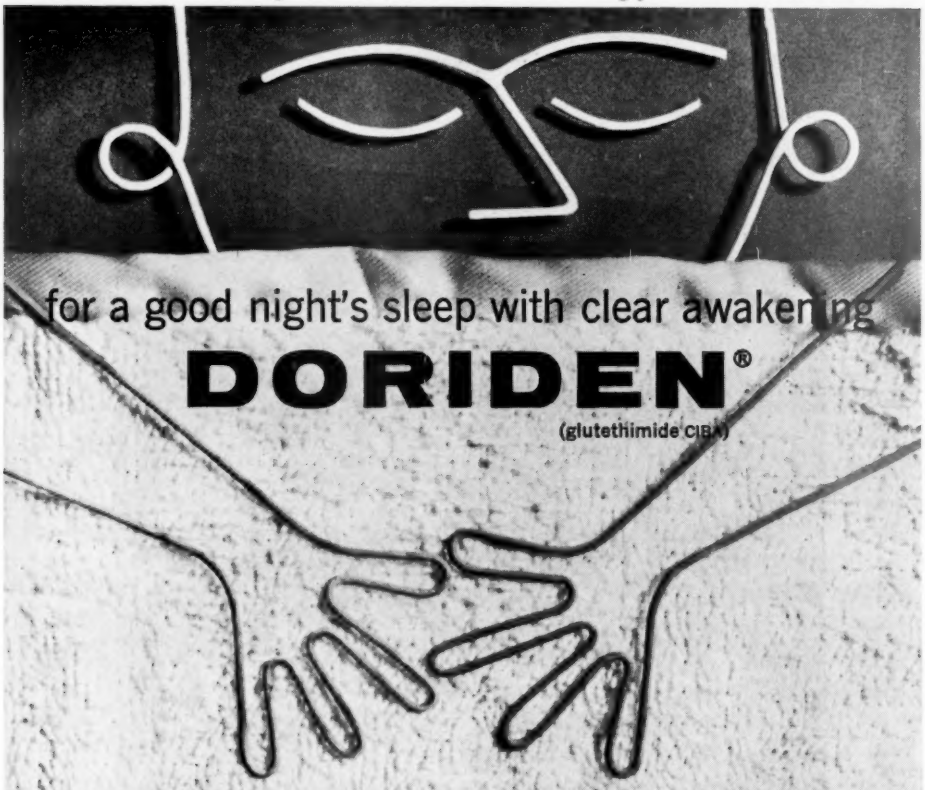

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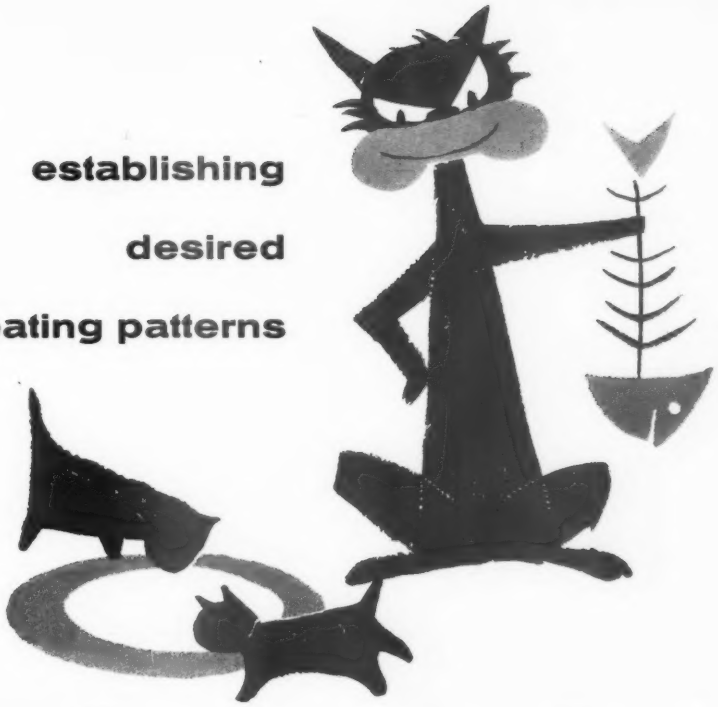

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1. Eisfelder, H. W.: Am. Pract. & Dig. Treat., 5:778 (Oct.) 1954.

2. Sebrell, W. H., Jr.: J.A.M.A., 152:42 (May) 1953.

3. Sherman, R. J., M.D.: Medical Times, 82:107 (Feb.) 1954.

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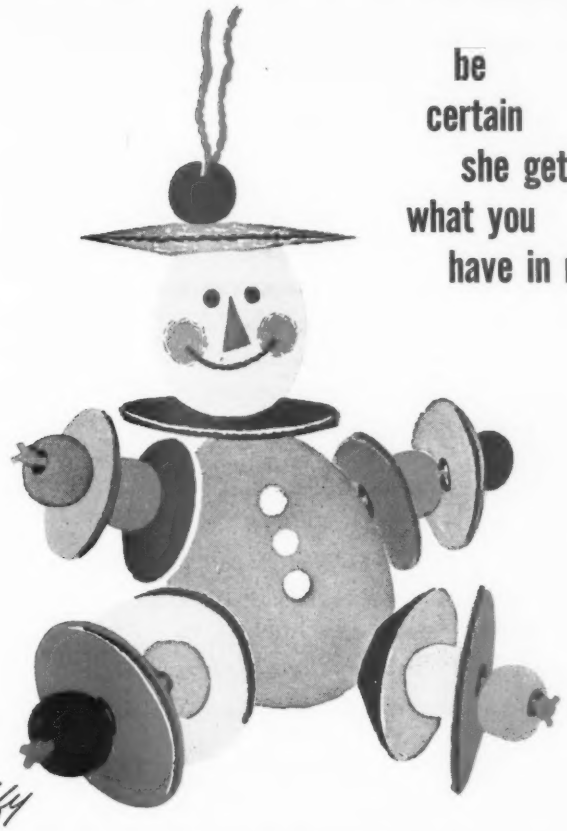

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1. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955.

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NEWS of ATOMIC ENERGY FOR CONSTRUCTIVE USES

Atomic energy in public health and medicine was the chief new topic on the agenda of the Eighth World Health Assembly opening in Mexico City on May 10, bringing WHO face to face with a difficult choice: Should it allocate its limited resources to a constructive international program for the use of radioisotopes in medicine and public health? Or should it give first priority to the protection of the health of populations as more and more countries launch programs for the peaceful use of atomic energy? The WHO Executive Board urges that priority should be given to health protection, but that WHO should, at the same time, undertake a long-range program to facilitate exchange of information on the medical use of radioactive substances and to help provide appropriate training for health personnel in these new techniques. All of this will have a profound influence on the future development of WHO's work, since radioisotopes have important uses in diagnosis, in therapy, in medico-biological research and other health fields. (Pan American Sanitary Bureau *News*, May 2, '55.)

* * *

To appraise present knowledge about the effects of atomic radiation on living organisms and to seek to identify questions upon which further intensive research is urgently needed is the purpose of a study to be undertaken by the National Academy of Sciences. The study will be financed by the Rockefeller Foundation and will be conducted by a committee of eminent scientists. In commenting on the study, AEC Chairman Lewis L. Strauss said: "From this study should come the necessary facts to clarify opinions in this important field of effects of radiation on human beings and their environments . . . The Commission will cooperate fully by providing information and consultation as desired by the independent scientists making the study."

* * *

Thirty-two scientists and technicians from 21 foreign nations were accepted as students for the special four-week Atoms-for-Peace radioisotope course at the Oak Ridge Institute of Nuclear Studies conducted during the month of May. The AEC has announced that another course will be held in the fall to take care of the overflow registration for this one. The registrants are from: Australia, Canada, Chile, Colombia, Cuba, Egypt, Finland, Germany, Greece, Guatemala, India, Italy, Japan, Mexico, Netherlands, Pakistan, Peru, the Philippines, Spain, Thailand, and Venezuela.

* * *

The first direct evidence of a toxic substance being produced as a result of radiation was reported in a paper presented in April before the National Academy of Sciences meeting in Washington by Dr. Abraham Edelmann of Brookhaven. The author found that "rats injected with serum from irradiated animals die sooner than those injected with serum from unirradiated animals. Thus the former serum clearly carried something toxic, a fact hitherto suspected but not proved."

News notes on Atomic Energy for Constructive Uses of interest to the medical profession will appear in these pages from time to time.

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THE HOOVER COMMISSION REPORT ON MEDICAL SERVICES

At the door of each of five Government entities lies responsibility for doing something about the Hoover Commission Report on Medical Services. All of the persons involved in this responsibility would welcome suggestions from thoughtful, authoritative, nonpartisan citizens.

Background facts on which findings and recommendations of the Commission are based indicate that 26 Federal Departments and agencies engage in one or more health activities entailing the curing and returning of soldiers to combat, alleviating the continued sufferings of veterans, protecting the population from epidemics, and caring for the mentally ill. In 1954 these medical services cost $4,149,000,000. The estimated increase for 1955 is $121 million. Of these total expenditures, the Department of Defense, the Veterans Administration, and the Department of Health, Education and Welfare account for some 90 percent.

Our Government has assumed specific responsibility for all or part of the medical care of 30 million of our 160 million people. This figure includes active duty military personnel, veterans with service-connected disabilities—both classes entitled to complete medical care; veterans, all of whom are eligible for care, on a facilities available basis, for nonservice-connected disabilities; dependents of military personnel and retired military personnel, also eligible for care on a facilities basis. Federal employees are eligible for limited on-the-job health services for occupational injuries or disease.

About 10 percent of all active physicians are employed by the Government, as are 9 percent of the active dentists, and 6 percent of the active graduate nurses. In Federal hospitals are to be found 13 percent of all hospital beds and about 7 percent of the total number of patients admitted to hospitals each year.

In 1949, the First Hoover Commission found that poor organization was characteristic of Federal medical services:

> "Four large and many smaller Government agencies, obtain funds and build hospitals with little knowledge of, and no regard for, the needs of the others. They compete with each other for scarce personnel. No one has responsibility for an overall plan. There is not even a clear definition of the classes of beneficiaries for whom care is to be planned. The Government is moving into uncalculated obligations without an understanding of their ultimate costs. . ."

The Hoover Commission's studies of 1954-55 indicate "little fundamental improvement. . ." Awareness of the need for reorganization has increased, but steps taken "do not reach fundamentals." Under the heading "Findings and Recommendations," the Commission says that the problems of the Federal medical services are the outgrowth of the expansion of these services and the problems of legislation surrounding this growth—together with the complexities introduced by "very proper effort" of Congress to save waste and duplication by unifying the military services. Congress will be the most important agency in solving these problems. Criticism is directed at the system, not at the personnel.

Research Memorandum Number Three issued by the Citizens Committee for the Hoover Report states that the Report raises two major questions for consideration by the Congress and the public: *FIRST,* where is the line drawn between health services and programs appropriately undertaken by the Federal Government and those which are not? and *SECOND,* how can we assure proper management of those health services which the Federal Government must continue to provide?

The Task Force for Medical Services working with the Commission made specific estimates of savings and costs involved in its recommendations, separate from those of the Commission.

Some of the recommendations of the Commission call for administrative action by the President and/or the Department of Defense and the Veterans Administration. Others call for the passage of basic law which will originate in the Senate Committee on Labor and Public Welfare (Lister Hill, (Ala.), Chairman), and in the House Committee on Interstate and Foreign Commerce, (J. Percy Priest, (Tenn.), Chairman). The Citizens Committee for the Hoover Report suggests that those involved in making decisions "will want to know what you think." (From a *Digest and Analysis of the Hoover Commission Report on Medical Services* by the Citizens Committee for the Hoover Report.)

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From the Four Corners

SOLO IN JAVA HAS A REHABILITATION PILOT PROJECT

Vocational training of the disabled at Solo in central Java, represents a victory of patience, hard work, doggedness, and dedication over social forces which used to regard disablement as just punishment for evil ways. Also to be surmounted were the absence of modern medical facilities, an inadequate medical corps, and seeming indifference in the early days of the hard-pressed Indonesian government.

Serving with the Indonesian Red Cross during the war, a young Indonesian surgeon, Dr. Raden Soeharso, became obsessed by the thought of what the future held for patients whose limbs he was amputating. Despite the opposition of superiors, who felt that working with artificial limbs was not a surgeon's business, he fought for the development of a rehabilitation centre, and, in 1946, went to Solo (also known as Surakarta) for that purpose. There, bitter fighting over a period of six years had left thousands in need of treatment and retraining. Hospital facilities were unavailable, but Dr. Soeharso set up shop in the hospital's garage. He enlisted the aid of a young engineer, Suroto, and together they learned from catalogues and experiments how to make artificial limbs . . . new legs and arms for the disabled from the scrap aluminum of crashed planes. Growth of facilities and the overcoming of prejudice have been gradual.

In 1951 Dr. Soeharso went to England on a fellowship and on his return, was able to establish three services: artificial limbs, vocational training, and resettlement for the war disabled. Later, there were classes in various trades with a full year course. To deal with a problem which loomed greater than that of the war disabled, the service began admitting the civliian handicapped. For crippled children, most of them victims of polio, Mrs. Soeharso led in the establishment of a children's centre.

When, in 1952, a call for help came from the government, the doctor made a deal: If the government would build him three wards, a recreation building, and an operating theatre, he would assume greater responsibility in rehabilitating veterans. Now Solo is the single modern rehabilitation centre in Indonesia. With a capacity of three hundred patients, it consists of some 20 hutments, connected by passageways protected from the sun and rain. The hutments contain offices, shops, dormitories, kitchens, laundry, the new recreation centre, the three wards and the operating theatre. There are about 200 staff members, including administrative personnel, as well as those working in the artificial limb shop, vocational training instructors, and social workers.

According to the UN, Dr. Soeharso has built up Solo into a "total concept" of rehabilitation work—that means, the care, guidance and retraining of the patient from the time he enters for treatment, is retrained in a new profession, and is finally replaced in useful civilian employment. The gap in the program has been lack of sufficient surgical help. This year the United Nations, the World Veterans Federation, the International Labour Organization, the World Health Organization, and the Colombo Plan are sending to Solo a team directed by an American orthopaedic surgeon, and consisting of an orthopaedic nurse, a physician therapist, and a vocational training and placement expert. Dr. Soeharso's work begun in a motor garage may become a pilot project for all of Asia. (UNESCO)

A SONGBIRD RECOVERS HER VOICE: EGYPT SETS UP A LABORATORY

Atomic medicines developed through U.S. medical research have restored to Egyptian audiences the voice of their first lady of song, Om Kalsoum Ibrahim. Her recovery from hyperthyroidism was brought about at the U.S. Naval Hospital at Bethesda, Maryland. When Madam Ibrahim's career seemed doomed, she came to America, having heard that atomic medicine held out great promise for sufferers with toxic goiter. Radioactive iodine, going to the diseased area bombards the thyroid with rays which destroy enough thyroid cells to reduce their harmful over-activity without harming the adjacent tissue. Three months after the treatment was begun, the singer demonstrated her recovery by singing at the Egyptian Embassy in Washington.

As a result of Madame Ibrahim's recovery, Egypt sent four of her scientists to the United States to study radioisotope techniques in the field of medicine, biology and agriculture. On their return to their own country, they will be accompanied by United States atomic specialists to establish a laboratory where other Egyptian scientists will be trained in radioisotope techniques.

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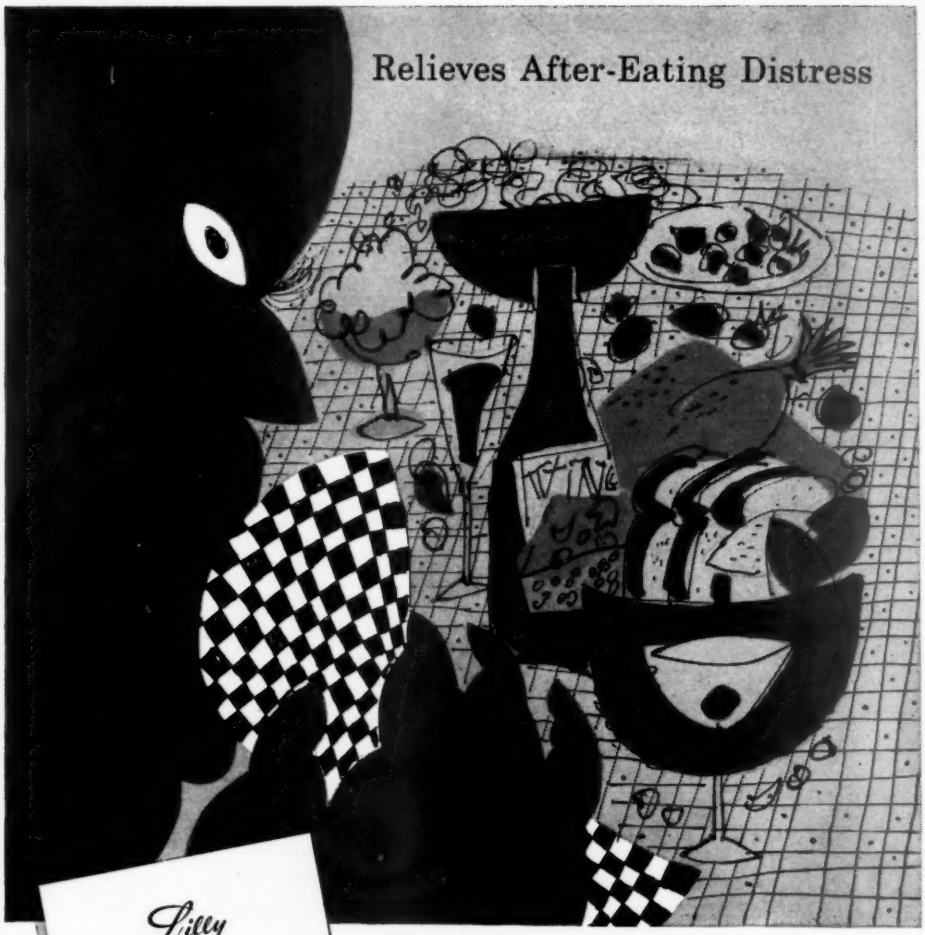

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VOLUME 10 JUNE 1955 NUMBER 6

Evidence of Esophageal Hernia in Chest Photofluorographic Surveys

Marian W. Perry, M.D.

CHEST PHOTOFLUOROGRAM SURVEYS for the detection of tuberculosis reveal a surprising number of other unsuspected conditions. One of these conditions is esophageal hiatus hernia. The photofluorogram (4 by 5 inches and 70 mm. film) is especially well adapted to demonstrate hiatus hernia, because of good penetration of the cardiac shadow. The usual roentgenographic finding shows an area of increased radiolucency behind the heart shadow in a round density with an air and fluid level (Fig. 1). In larger hernias, the abnormal shadow extends beyond the heart borders (Fig. 2).

In the chest photofluorogram surveys of the Massachusetts Department Public Health, all persons showing abnormal or questionable films are requested to return for a standard chest film of 14 by 17 inches. These films are taken with a portable 15 milliampere x-ray equipment. Often the hernia will not be demonstrated by this technique on the posterior-anterior view, although it can be seen on the lateral film (Fig. 3). Two persons, each with a large hernia which extended beyond the heart shadow and had the same density as the heart, were interpreted as having enlarged hearts. Survey films at a later date showed a definite air-fluid level with a contrasting density, and were correctly diagnosed.

Dr. Perry is Senior Physician, New England Hospital; and Public Health Physician, Massachuetts Department of Public Health, Boston, Massachusetts.

INCIDENCE

In 802,718 films taken in surveys for tuberculosis in persons 15 years of age and over, 213 persons were found with photofluorographic evidence of hiatus hernia. It is important to recognize that all films were made of the subject in a standing position, and that clothing was worn when the miniature film was made. (Trendelenburg position usually is employed by the roentgenologist to demonstrate hiatus hernia; barium meal and abdominal pressure are further aids.) It is, therefore, obvious that the 213 cases revealed in the routine surveys do not represent the true incidence. Kirklin and Hodgson[1] found diaphragmatic hernia in between 1 and 2 percent of all gastrointestinal examinations, and more than 98 percent of these were hiatus hernia. Evans[2] found 3.4 percent diaphragmatic hernias in 6,124 upper gastrointestinal examinations, and 190 of these cases, or 89.6 percent, were hiatus hernia. Brick[3] reported that hiatus hernia was demonstrated in 8.93 percent of 3,448 patients undergoing gastrointestinal studies; according to him, duodenal ulcer is the most common upper digestive tract lesion; hiatus hernia is the second most common pathologic lesion of the upper tract and is the most common type of hernia.

It has been recognized that hernia through the esophageal hiatus occurs most commonly in women. Table I shows sex and age distribution of the cases found in this study. Sample counts of the total number examined suggest that there is a slightly greater number of females than males in the total survey.

TABLE I

Sex and Age Distribution of Hiatus Hernia in 213 Persons

AGE GROUP (years)	FEMALE	MALE	TOTAL	PERCENT
20-29	1	0	1	.47
30-39	7	1	8	3.76
40-49	16	4	20	9.39
50-59	49	7	56	26.29
60-69	77	4	81	38.03
70-79	32	4	36	16.90
80 and over	6	0	6	2.82
Age not stated	4	1	5	2.34
Totals	192	21	213	100.00

21, or less than 10 percent of the group, were males.

Symptoms

It was possible to interview only 125 persons regarding symptoms or previous knowledge of the hernia. Symptoms which could be attributed to the hernia were elicited in 105 persons. Of the 20 who admitted no symptoms, 4 were then under treatment for hernia.

Pain headed the list of symptoms, with gaseous eructation and heartburn second. Table II lists symptoms in order of frequency.

Pain varied in location. The epigastric area was the most common location; midchest and substernal region the second most common location. The third most common area of pain appeared in the left anterior costophrenic region or in the back. Pain in the left shoulder and left arm was not infrequent (one person reported pain in both shoulders). Abdominal pain in the right upper quadrant radiating to the back was reported by two persons.

Hiatus hernia simulates many other conditions (see Table III). The pain caused by hiatus hernia may simulate angina pectoris. Thirteen, or 10.4 percent of the 125 persons interviewed had a previous diagnosis or suspicion of heart disease. Nuzum[4] studied 100 private patients with a diagnosis of angina pectoris; he found 25 hernias of the esophageal hiatus and 7 patients were judged to have no heart disease. Bochus[5] points out that the afferent pain fibers from the myocardium, lower esophagus, and stomach are carried almost entirely over sympathetic pathways. He also states his impression that vagal afferent impulses originating in the lower esophagus and stomach may, under certain circumstances (in the presence of myocardial damage), decrease coronary blood flow.

TABLE II

Symptoms, According to Frequency

SYMPTOM	NUMBER
Pain	45
Gaseous eructation and heartburn	41
Dyspnea	28
Palpitation	18
Vomiting	13
Nausea	9
Cough	11
Weakness and fainting spells	10
Regurgitation	6
Hematemesis	3

Gallbladder disease is often suggested by the symptoms and sometimes actually co-exists. Gallbladder disease had been diagnosed 23 times, or in 18.4 percent of the persons interviewed; 12 of the 23 reported that they had had a cholecystectomy. In a series of 448 cases, Harrington[6] noted an average of three erroneous diagnoses in his cases of hiatus hernia before the correct diagnosis was made.

The literature contains numerous articles on hypochromic anemia caused by hiatus hernia. Herniation may interfere with the blood supply and result in mucosal bleeding. Anemia results from insidious bleeding from the mucosa or frank hematemesis with ulceration. Of the 125 persons interviewed, 14 or 11.2 percent had been told by their physicians that they had anemia; 9 persons reported weakness or fainting spells which may have resulted from blood loss; 3 reported hematemesis; 1 had tarry stools; and 4 had had gastric ulcer, 2 with bleeding. In a group treated by Adams and Lobb[6] 41 percent had anemia. It is the opinion of the writer that if the results of hemoglobin determinations were available for the survey group, the percentage with anemia would have been much higher.

Adams and Lobb presented a case history of a

Fig. 1

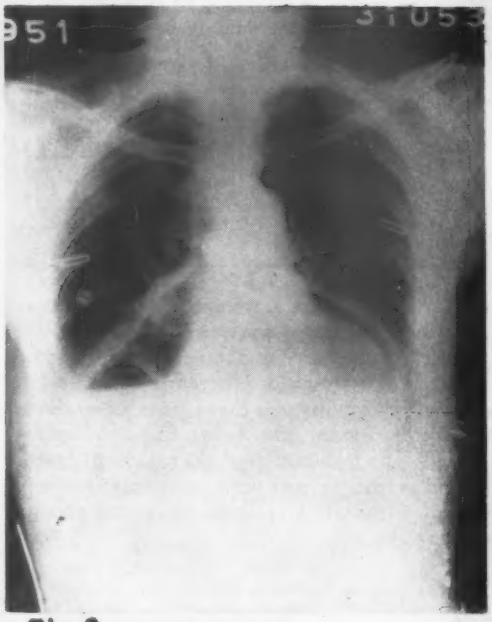

Fig. 2

Fig. 1. Usual roentgenographic finding shows area of increased radiolucency behind heart shadow in a round density with air and fluid level.

Fig. 2. In larger hernias, abnormal shadow extends beyond heart borders.

Fig. 3

Fig. 3. Hernia seen on lateral film.

TABLE III

Conditions Which May Simulate or Co-Exist With Hiatus Hernias Reported by 125 Persons Found to Have Hiatus Hernia

NUMBER INTERVIEWED	125	PERCENT
Gallbladder disease (with surgery)	23 (12)	18.4 (9.6)
Heart disease	13	10.4
Anemia	14	11.2
Gastric ulcer	4	3.2

woman who had typical asthmatic attacks relieved by repair of an esophageal hiatus hernia.

Since hiatus hernia simulates angina pectoris, gallbladder disease, and many other conditions, it is obvious that a diagnosis cannot be made on symptoms or by physical examination. Routine chest examination by miniature photofluorogram of hospital and outpatient cases would undoubtedly reveal cases of hiatus hernia which are overlooked without such examination.

Treatment

Treatment of hiatus hernia in the presence of symptoms may be either surgical or medical. It is reported that medical treatment is fairly successful with a bland high caloric diet, four to six feedings, upright position for two hours after eating, and sleeping at an angle of 45 degrees. Weight reduction and avoidance of bending or stooping are also advisable to prevent increased intra-abdominal pressure. Tight girdles should not be worn, and emotional trauma should be avoided. Atropine and alkalis may be necessary.

Harrington[7] recommends surgery if one third or more of the stomach is in the thoracic cavity. Evans[2] recommends early surgery to prevent chronic esophagitis from reflux of acid gastric juices into the lower esophageal segment with its resulting ulceration, stenosis, and shortening of the distal esophagus with fixation of the herniated stomach. Chronic hypochromic anemia and failure of medical treatment should certainly indicate consideration of surgical treatment. Such emergencies as incarceration, strangulation, and obstruction are absolute indications for surgery. Some surgeons prefer the thoracic approach and some the abdominal. Sweet[8] finds the supradiaphragmatic approach easier because of better visualization from above the diaphragm, and also reports fewer complications and fewer recurrences.

Summary

Miniature chest photofluorographic films of 802,718 persons examined in surveys for the discovery of tuberculosis showed roentgenographic evidence of 213 cases of hiatus hernia.

1. A medical history was obtained from 125 persons; the others failed to return for the repeat film on standard 14 by 17 inches chest film which is routinely requested before the findings are reported to the private physician.

2. The incidence was far greater in women than in men and was more common after the age of 50 years.

3. Symptoms appear to be common in hiatal hernia; most common are pain and heartburn with gaseous eructation.

4. Hiatus hernia is a great mimic of gallbladder disease, heart disease, and other conditions which may, however, co-exist with the hernia.

5. Knowledge of the presence of a hiatus hernia may prevent an erroneous diagnosis of other diseases and may explain the cause of a hypochromic anemia.

6. Treatment may be surgical or medical.

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Recent Advances in Surgery

CLINICAL APPLICATIONS OF ENZYMES

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WITHIN THE PAST FIVE YEARS, the science of enzymology has emerged from the test tube and textbook and has become a potent physiologic tool. In the hands of the surgeon, it is a tool that can distinguish between necrotic cells and living cells, a distinction that is not always possible with the scalpel.

Enzymes are proteins, widely distributed in the human internal environment, both intracellularly and extracellularly. They catalyze every important process, and serious derangement of enzyme systems inevitably results in malfunction. Theoretically,[1] influence of vital processes is possible by influence of their regulatory enzymes; but practically, the peptidases, which depolymerize long protein chains, are the chief clinically applicable enzymes.

Trypsin is a normally occurring, proteolytic enzyme of the pancreas. Besides its function in digestion, it has been shown to have two dissimilar actions when injected into animals. In small amounts, trypsin is a blood-clotting agent, in vitro and in vivo. Injected intravenously into rabbits, it results in immediate death by intravascular and intracardiac thrombosis. In large amounts, trypsin causes destruction of the blood-clotting mechanism by its digestion of blood proteins. Both these known reactions of trypsin have been utilized in therapy. Moderate amounts of trypsin given intravenously to patients suffering from hemophilia have been used to shorten the prolonged clotting time. The effect is transient, but occasionally has proved beneficial.

More recently, the treatment of thrombophlebitis by the use of intravenous and intramuscular trypsin has been investigated by Innerfield[2] and co-workers. In a series of 538 patients treated with intravenous trypsin, they reported disappearance of the clot, return of circulation to the involved venous segment, and decrease of edema.

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The dosage of trypsin given was 10 to 15 mg. of crystalline trypsin in 100 cc. of normal saline, twice daily for five to seven days. The rate of administration was 30 drops per minute. With this slow rate, the only complication was occasional thrombosis of the injection site. Histadyl® was given prophylactically in the solution, since it is known that trypsin releases histamine.

Blood studies on patients treated with intravenous trypsin revealed a drop in prothrombin to 86 percent of normal, a decrease in fibrinogen from 350 to 330 mg. percent. There was a slight decrease in factor 5. The coagulation time was prolonged from five to eight minutes. There was some fibrinolysis of clot.

Although there were no serious complications from intravenous administration in the above large series, Taylor[3] believes that in amounts large enough to dissolve clots, all the blood proteins will be lysed; and therefore trypsin, for intravenous use, is too dangerous. At the present time, trypsin for intravenous administration has been withdrawn from the market.

Therapy with intramuscular trypsin is undoubtedly safer. An intramuscular preparation is available under the name of parenzyme®. In 18 patients with chronic, recurrent phlebitis treated with intramuscular trypsin, Innerfield[4] believes the course of the phlebitis was shortened. Embolization occurred in one percent, but there was no mortality. Seven patients had had infarcts before treatment, with 3 patients having had multiple infarctions. Trypsin in sesame oil was given intragluteally in doses of 2.5 mg. in 0.5 cc. daily for 5 to 13 weeks. All showed improvement, but 15 of the group had recurrences after cessation of treatment. The inflammation subsided with resumption of trypsin, and the patients are now maintained on weekly injections.

Some authors believe that there is constant intravascular clotting with removal of the clots by a fibrinolysin present in the blood. Innerfield[4] postulates that patients with recurrent thrombophlebitis have a deficiency of fibrinolysin, and that small amounts of trypsin activate a latent lytic substance in the blood.

There are two less controversial uses for trypsin

that have proved effective.[3-8] Injected into body cavities or used on contaminated surfaces, it dissolves coagulums, decreases viscosity of exudates, and promotes phagocytosis. Its use has been reported in tuberculous empyema,[9] on contaminated amputation stumps, in diabetic gangrene, and on sloughing and infected cancerous, varicose, and decubitus ulcers.[1] Hematomas in postoperative wounds have been liquefied within one hour.

In tuberculous empyema, current methods of therapy involving aspiration and instillation of antibiotics do not control over 50 percent of patients because the antibiotics cannot penetrate the thick abscess membrane. Trypsin in doses of 600 mg. dissolved in 60 cc. of Sorensen's buffer can be instilled into these cavities following aspiration. Intrapleural pressure is then adjusted to the highest negative value comfortable on deep inspiration. Four to eight hours after instillation, there may be a temperature rise of from 1 to 3 degrees. This returns to normal within two hours and, as treatment continues, there is no further rise. Instillation should be repeated every 24 hours. Viscosity of the contents rapidly declines and aspiration becomes easy. Some cases re-expand spontaneously or can be more easily treated by thoracoplasty after control of infection. After four to seven injections, grossly bloody fluid may appear, and treatment should be stopped temporarily.

Crystalline trypsin may also be used in aerosol form.[10,11,12] It is administered in a nebulizer with oxygen flow under pressure. The first dose is 50,000 units dissolved in buffer, and this may be increased to 100,000 or 200,000 units as treatment progresses. Productive coughing usually begins after 15 minutes. The sputum diminishes in viscosity and, with further treatment, in amount. This method is useful in acute atelectasis, unresolved pneumonitis, inoperable bronchiectasis, chronic emphysema with bronchitis, and lung abscess.

Pancreatic dornase has also been used in similar conditions by inhalation.[13]

Hemolytic streptococci elaborate enzymes that have been put to therapeutic use. In 1934, Tillett and Garner[14] observed that broth cultures of hemolytic streptococci could cause rapid lysis in the fibrin clots of normal human blood. Further studies have shown that this is owing to the presence of an enzyme activator that catalyzes the conversion of a proenzyme, plasminogen, to plasmin. Plasmin is present in the euglobulin fraction of plasma proteins, and is a fibrinolysin. The enzyme activator has been called streptokinase. During exploratory studies of streptokinase, it was observed that injections of crude concentrations of the enzyme could also cause liquefaction of purulent exudates. This has subsequently been found to be caused by the presence of a true enzyme, streptodornase, which catalyzes the hydrolysis of those nucleoproteins which contain desoxypentose nucleic acid. Streptodornase acts chiefly on leukocytes. The action of streptokinase depends upon the supply of plasma to the area, the concentration of plasminogen in serum, and the presence of varying amounts of antistreptokinase from immune response to other streptococcal infections.

Provided these enzymes have adequate access to purulent and fibrinous deposits, application will result in medical débridement. Varidase®, as the combination of these two enzymes is known commercially, is not used parenterally. It is only for local application or instillation into body or abscess cavities. For the latter purpose, 200,000 units of SK (streptokinase) and 50,000 units of SD (streptodornase) are dissolved in 10 to 20 cc. of saline. For local application, it may be used in powder form or in a gel.

Clinical applications[6,15-19] have included its use in hemothorax, postoperative or traumatic, sterile or infected; in hemopericarditis; in empyema;[20] for the lysis of hematomas; on necrotic and suppurative wounds and infected burns; and in chronic osteomyelitis, amebic abscess of the liver, suppurative tuberculous adenitis, chronic sinusitis, and meningitis. Its use has been reported in subphrenic abscess, pararectal abscess, and lesser peritoneal sac infection following esophageal perforation. Wright[21] and associates have reported promising experimental results in the prevention of postoperative adhesions in rabbits.

Contraindications to the use of varidase are the presence of active hemorrhage and acute cellulitis without suppuration.

Investigations of varidase toxicity[22] have revealed febrile reactions, transitory red cells and casts in the urine, proteinuria and glycosuria in some cases, leukocytosis of from four thousand to eighteen thousand above normal, and an increase in metamyelocytes. No changes in the red cells or the clotting mechanism have been found. Cephalin flocculations were negative. All the above reactions are probably on the basis of reactions to nonspecific protein therapy.

Neither trypsin nor varidase will lyse collagen. They are therefore useless in chronic infections where fibrous tissue is present. For this purpose, a collagenase is needed; and such an enzyme has been isolated and partially purified from strains of Clostridium[23] and from maggot cultures.[24] Cl. histolyticum, a normal soil inhabitant, has served as a potent source of collagenase for experimental work. In the animal laboratory, this enzyme has been re-

markably effective in loosening burn eschars and in the dissolution of tendon, fascia, and dermis wounds. On human beings also it is effective when adequate contact can be obtained with its substrate. It shows little effect upon granulation or on normal tissue beyond an occasional reddening.

Recently clinical attention[25] has been forcibly called to the role of proteolytic enzymes of the blood, which produce massive hemorrhage. Normally, human plasma does not exhibit detectable proteolytic activity on a fibrinogen substrate, though it has long been known that the blood of cadavers will liquefy after initial clotting. In certain conditions of acute emotional upset,[26] anxiety, or shock caused by trauma, burns, and hemorrhage, fibrinolytic activity can be observed. It sometimes destroys the coagulation mechanism, producing death. Certain tissues, such as lung tissue, contain activators of plasminogen, so that operations on the lung frequently produce fibrinolysis of some degree. The prostate also contains a fibrinolysin, and prostatic operations and prostatic carcinomas release enough proteolytic enzyme to cause hemorrhage or hemorrhagic tendencies. Mild bleeding tendency in carcinoma of the prostate can be controlled by treatment with estrogens; testosterone in this disease increases hemorrhage.

In fibrinolysis caused by activation of plasminogen to plasmin, an antiplasmin can be used in therapy. This antienzyme exists in the albumen fraction of plasma, and can be obtained when albumen is separated with salt, but not with ethanol. Ungar and Damgaard[27] have recently reported that the balance between plasmin and antiplasmin is controlled by the pituitary, through stimulation of adrenal cortical hormones. These hormones accelerate combination of the fibrinolytic enzyme with its inhibitor. This apparently occurs in the spleen.

Scott and others[25] have recently reported 5 cases of plasminemia treated with serum albumen. Four of the patients were successfully controlled. When no local cause can be found for massive hemorrhage, and if the patient's blood clotted normally before operation, a diagnosis of plasminemia should be considered. When plasminemia is present, the coagulation time may be normal or may be infinitely prolonged. Plasminemia must be distinguished from hyperheparinemia, which may occur under similar circumstances. In plasminemia, addition of small amounts of the patient's blood to normal blood will not prolong the coagulation time. In hyperheparinemia, normal clotting time is prolonged by this procedure. If the blood does not clot in plasminemia, addition of small amounts of thrombin will not produce a clot. In hyperheparinemia, addition of thrombin will cause clotting. In plasminemia, if a clot forms, it will begin to lyse in 30 to 60 minutes and will disintegrate completely within 24 hours. Clinically, the patient shows a continuous ooze from all cut surfaces and from venipuncture sites.

Therapy of plasminemia is administration of whole blood to supply the coagulation factors being destroyed and the antiplasmin present in normal serum. One hundred to 300 ml. of low salt serum albumen should also be administered. Improvement of coagulability is usually noted within 30 minutes. Lewis and Ferguson[28] have suggested the possibility that soybean trypsin inhibitor will correct the shock resulting from plasminogen activation.

If the diagnosis of hyperheparinemia is made by the methods suggested above, therapy may be instituted with toluidine blue, which is an antiheparin. The dosage is 5 mg. per kilogram of body weight.

Many other enzymes have applications that are known.[1,6] Hyaluronidase, another streptococcal product, is used as a spreading factor in fluid administration and in sprains. It is being studied for use in sterility cases and in the treatment of arthritis. Beta-glucuronidase is helpful in the diagnosis of carcinoma of the endometrium. Cholinesterase determinations aid in the diagnosis of liver disease; acid phosphatase, in the diagnosis of carcinoma with metastases from the prostate; and lysozyme as an indicator of the activity of ulcerative colitis.[29] Mucinases are now being studied[30] as causative agents in ulcerative colitis. Jacques[31] has reported calcium pantothenate to be helpful in the therapy of paralytic ileus. This is the soluble calcium salt of pantothenic acid, a component of coenzyme A, concerned in the formation of acetylcholine.

The potentialities of enzymes in the diagnosis and management of disease have been applied clinically only recently. Extension of these applications may open many new fields and present a rational approach to many disease entities that are now treated empirically.

Summary

This is a review of the recent attempts to apply the developing science of enzymology to clinical practice. At present the successful use of enzymes is confined to the peptidases. No success has been attained in attempting to influence the intracellular enzymes. The use of enzymatic débridement of wounds is discussed. Mention is made of some of the methods being developed for using enzymes in making diagnoses. It is hoped that progress will be made in localizing the sites of action of administered enzymatic agents.

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Treatment and Rehabilitation of Alcohol Addicts in a General Hospital Setting

Martha Brunner-Orne, M.D.

DURING RECENT YEARS, the concepts regarding alcoholism and its treatment have undergone considerable change. The alcoholic patient is now considered a sick person rather than a culprit, and the medical profession has finally conceded that the treatment of alcoholic persons is one of its responsibilities. Alcoholism is looked upon as a disease, or, more particularly, as a symptom of various underlying pathologic changes. According to the opinion of many workers in this field, alcoholism may not be attributable to one particular reason but be owing to a combination or interaction of several factors.[1] There may be some constitutional predisposition,[2] or there may be other organic reasons such as deficiency of the endocrine glandular system.[3] Low resistance to physical and emotional strain, found in many alcoholic patients, may be related to disorders of the pituitary-adrenal system. Or early psychic trauma combined with unfavorable environmental conditions may lead to the need for defense mechanisms,[4] such as excessive use of alcohol. Once a person resorts regularly to its intemperate use, so-called secondary symptoms develop and new complications are added to the underlying conflict situation.

The alcoholic becomes run-down physically (vitamin deficiency, liver damage, neuritis, and so forth), and equally deteriorated emotionally and socially. In order to go on he has to take a drink in the morning and soon becomes a victim of the well-known "vicious circle."

In our treatment of alcoholics, we try to break this vicious circle by relieving the secondary symptoms first. This can be done most efficiently during a short period of hospitalization where in addition to physical treatment the patient finds sympathy and understanding in place of the contempt and punishment he has had to face in the past. In this hospital atmosphere, he more quickly regains his self-respect and confidence. He becomes amenable to suggestion and ready to accept an extended rehabilitation program.

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In March 1951, a pilot study on the effect of short hospitalization periods for alcoholics was started at the New England Hospital in Boston, Massachusetts. This study was sponsored by the Division of Alcoholism of the Massachusetts Department of Public Health, and carried out from March 1951 to June 1952. The hospitalization for 24 indigent patients was subsidized by the Commonwealth of Massachusetts. During this period, about two hundred other alcoholic men and women were also admitted to the hospital, who were able to finance their own hospitalization, or who belonged to the Massachusetts Hospital Service, Inc. (Blue Cross) and the Massachusetts Medical Service (Blue Shield). These organizations have become aware of the crucial situation of many alcoholics and are willing to cover a hospitalization period of up to ten days' duration. The average hospital stay of our patients was six days.

In each case, a complete physical examination was performed, including blood sugar and liver function tests. Additional studies, such as roentgenogram, basal metabolism, and electrocardiogram, were performed when indicated. An attempt was made to establish a medical as well as a psychiatric diagnosis. In most cases, psychologic tests were performed after the patient was sober (Rorschach, Wechsler-Bellevue, TAT, and so forth, as indicated). A simple psychomotor test battery is now being developed which will make it possible to determine the degree of intoxication and to evaluate the efficiency of various treatment methods.

New methods have been evolved to treat the patient in the stage of acute alcohol intoxication. Thorazine® [5,6] (chlorpromazine hydrochloride) has proved effective, and, although a new drug, is used extensively. It has a sedative, hypotensive action, and potentiates sedatives and narcotics, intensifying and prolonging their action. In France, it is widely used under the name "largactil." We have started to use this drug for prolonged sleep as well as in

the treatment of acute alcohol intoxication. Thorazine is given, if possible, by mouth, 25 to 50 mg. three times a day, and at bedtime. If necessary, it is given intramuscularly. If thorazine is not tolerated, or not advisable because of liver involvement, we resort to tolserol® which combats tension states and other withdrawal symptoms. We have used it with success as a substitute for barbiturates which we try to exclude from our treatment.

So far, cases of delirium tremens or acute hallucinosis have been excluded from admission to the New England Hopital. In cases with mild confusion, 30 cc. of 50 percent glucose combined with thiamine, given intravenously, has proved more successful and expedient than intravenous infusions of saline solution (500 to 1,000 cc. with 5 percent glucose). In any case where convulsions were reported, dilantin® sodium was given to prevent seizures during the withdrawal period.

The plan of therapy was focused first on a rapid and thorough physical build-up. In patients with normal blood sugar levels, insulin stimulation was given. This is not a new treatment. We have been using insulin stimulation for years and feel that it is beneficial from a psychologic as well as physiologic viewpoint. What we aim for is thorough stimulation of the glandular system. We explain to the patient that there is a correlation between the action of the various glands, especially between insulin and the hormones of the pituitary gland, which, in turn, controls the function of the entire glandular system; and that to obtain sufficient stimulation we give increasing amounts of insulin to produce various systemic reactions: profuse perspiration, palpitation, dizziness, drowsiness, difficulty in focusing, and so forth. The patient is told that he is being carefully observed and that any unpleasant reaction can be relieved immediately. If instructed in such a manner, patients anticipate the reactions without fear and even feel disappointed if they do not experience certain sensations.

We found that giving insulin at 6 a.m. is advantageous because the routine is easily adapted in a general hospital. The daily dosage depends on the reaction of the individual patient and may be increased up to 30 to 50 units. The individual treatment is terminated after three hours if no need for termination occurs sooner. It is amazing how promptly the patients reacted to this treatment with ravenous appetite and a feeling of well-being. Weight gains up to 10 pounds in five to eight days were recorded. This treatment has been described in detail because it can be employed easily in general hospital wards.

Additional medication consisted of sodium chloride for the first few days, and vitamins orally or intravenously. Recently we have been using honey, 250 Gm. in divided doses at one-half hourly intervals, following a suggestion of Martensen-Larsen.[7] Honey contains a large amount of fructose which has been found to promote the metabolism of alcohol. The fructose-alcohol reaction has also a "sobering-up" and sedative effect on the patient, corresponding to the effect of vitamin B_6 and the combination of both has proved most beneficial.

We also used other treatment methods as, for instance, ACE and ACTH,[8] but discontinued these because the results did not exceed those obtained from insulin and glucose.

Antabuse®, in combination with antihistamine drugs and sodium chloride, as recommended by Martensen-Larsen,[9] was used, but has now been replaced by the combination of antabuse with thorazine. Martensen-Larsen recommends this as a routine treatment, but we use it only in cases which have been on antabuse medication. The patient falls into a deep coma-like sleep and is relaxed and sober on awakening. In selected cases, where the patient could stay in the hospital for only a very limited time because of pressure from home or work, the combination of antabuse and thorazine has been of great value.

As thorazine alone, or combined with very small doses of sedatives, has proved successful, we have eliminated the use of antabuse almost completely during the acute state of intoxication. However, antabuse, when used as an adjunct in a general rehabilitation program, is of great value and is used extensively. Our technique in administering this medication has changed. Now we give it in small doses starting with 0.75 Gm. daily (0.25 Gm. three times a day), building up the blood level during the patient's stay in the hospital and advising him to take a maintenance dose which varies individually. Often we refrain from giving "antabuse trials" or the so-called "whiskey test," since the biologic reaction to alcohol when given in combination with antabuse was given more than adequate recognition.

Antabuse sets free energy needed to combat the craving for liquor and the temptation to take a drink. If given without supportive measures, there may be some danger, but when administered as a part of a well-planned treatment program, under which side effects and complications can be avoided, it has proved very helpful.

The short hospitalization period[10] offers an excellent opportunity to initiate a rehabilitation program based on the three-fold approach, physical, emotional, and environmental. The general hospital with its various departments is well equipped to deal with any physical complications. Once the secondary symptoms are relieved, the emotional prob-

lems can be treated by individual psychiatric interviews where the patient can discuss his problems. While in the hospital, the patient can be encouraged to attend the rehabilitation clinic. The one in the New England Hospital was opened in 1950 and operates once weekly. Here the patients are seen in individual psychotherapeutic interviews, supplemented by group therapy, which has proved to be a valuable tool in the treatment program of alcoholics.[11] Members of the patient's family are invited to attend the sessions and gain understanding of his problems.

To treat an alcoholic successfully, one has to work with those closely connected with his life.[12] The social worker usually available in the setting of a general hospital can play an important part in establishing contact between the patient, his family, the proper community agencies, and Alcoholics Anonymous. The social worker should supervise and encourage the regular attendance of the patient at outpatient clinic and group sessions after the short hospitalization period. The ultimate goal is not only sobriety, but also helping the patient to develop more mature reaction patterns and to readjust to a normal family and community life.

Summary

We have tried to point out the importance and advantages of admitting alcoholics to a general hospital. It is difficult to persuade an alcoholic when sober to seek help and treatment. However, during the acute stage of intoxication and during the period of hang-over, he is in need of medical attention and is then usually willing to submit to hospitalization. The effectiveness of new treatment methods facilitates the handling of alcoholics in a general hospital setting, and is instrumental in breaking down the reluctance of hospital authorities to accept alcoholics when acutely intoxicated.

Short-term hospitalization followed by a long term rehabilitation program have proved effective. Modern treatment methods (thorazine, hypertonic glucose solution, and so forth) make it possible to handle alcoholics in a general hospital, at any state, including acute intoxication. In March 1951, a pilot study on the effect of short hospitalization periods was started at the New England Hospital, Boston, Massachusetts. Twenty-four patients were admitted under the state plan, and about two hundred other patients have been admitted since.

Therapy was focused primarily on a rapid and thorough physical build-up. Insulin stimulation proved highly effective and can well be carried out in a general hospital for private and ward patients. While the patient is in the hospital, a rehabilitation program can be initiated, either at the hospital outpatient clinic, or he can be referred to other clinics located near his home or work.

Short-term hospitalization has been such a positive contribution to the treatment of alcoholism, especially with the new treatment methods available, that we hope other hospitals will be willing to accept alcoholics for treatment and for the initiation of a long range treatment program.

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CASE REPORT

Thyroid Function in Infant with Congenital Goiter Resulting from Exposure to Propylthiouracil

Clara Waldinger, M.D., M.P.H., Olga S. Wermer, M.D., and Edna H. Sobel, M.D.

THE MANAGEMENT of thyrotoxicosis in pregnancy presents special problems, since the welfare of both fetus and mother must be considered. Without specific therapy, premature termination of the pregnancy is to be expected. Too little is known of the time required for complete elimination of a therapeutic dose of radioactive iodine to permit its use even early in pregnancy, as the fetal thyroid is able to concentrate iodine by the third month of gestation.[1,2] In patients who have considerable exophthalmos, either radioiodine treatment or surgery are commonly avoided, since these are likely to be associated with a greater frequency of malignant exophthalmos.[3] In some instances, there are other factors, medical or personal, in the maternal situation which may be considered to preclude surgical management. Propylthiouracil and related antithyroid compounds are known to cross the placenta and affect the fetal thyroid of animals.[4] Although the majority of human newborns exposed to antithyroid drugs during gestation show no apparent ill-effects,[5] nevertheless the incidence of goiter in infants of mothers treated with large doses of propylthiouracil has been reported to be as high as 20 to 30 percent.[6] The goiters usually do not produce any symptoms, and gradually disappear spontaneously or in conjunction with the administration of thyroid hormone. There are, however, instances of hypothyroidism in the newborn,[7,8] and in one case thyrotoxicosis developed at four years of age in a child who had previously required thyroid hormone therapy because of hypothyroidism developing after birth.[9]

An instance of neonatal goiter with special studies and appraisal of thyroid function is given in the following presentation:

CASE REPORT

H.D., a housewife, aged 40 years, was first seen at the outpatient department of the New England Hospital on January 30, 1951. Three months previously, in the last month of her eighth pregnancy, she developed hypertension and, shortly thereafter, symptoms of thyrotoxicosis. She was treated with propylthiouracil, 100 mg. every 8 hours, but took the drug irregularly. Symptoms of thyrotoxicosis recurred late in 1951, during her ninth pregnancy and again in May 1953, four months after a miscarriage. Propylthiouracil, 150 mg. every 8 hours, was now prescribed by the endocrine clinic. She improved considerably and the dose was reduced to 100 mg. every 8 hours after two months. In November 1953, in the fourth month of her eleventh pregnancy, her thyrotoxicosis was well controlled. In the eighth month of the pregnancy, she discontinued medication for about two weeks, but otherwise followed the prescribed regime. On April 24, 1954, the infant was born. Therapy continued after delivery, and, in January 1955, was decreased to 50 mg. every 8 hours as there were early signs of hypothyroidism.

The infant, born on April 24, 1954, was a female; weight 7 pounds, 1 ounce; length 52 cm. The infant was in good general condition. The thyroid gland was soft, symmetrically enlarged to about four times the normal size, and without signs of increased vascularity. There was no evidence of interference with respiration or swallowing, or of vascular obstruction. The child's hemoglobin was 16.8 Gm. percent, the red cell count was 4.64 million. Roentgenograms of the neck and chest disclosed a soft tissue swelling which did not displace other structures (see Figure). Skeletal maturation was normal for a newborn girl. The child did well on an evaporated milk formula and required no special treatment. Breast feeding was avoided because it is known that propylthiouracil is excreted in the milk.[10] At four weeks of age, the baby was admitted to the Beth Israel Hospital for evaluation of thyroid function. She weighed 7 pounds, 10 ounces, and was 52 cm. long. The thyroid gland was about three times normal size,

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Lateral view of the neck of child aged 3 days

smooth and soft. The radioiodine uptake was 86 percent in 24 hours (normal 30 to 50 percent). The protein-bound iodine was 7.1 micrograms percent, which is normal. Hemoglobin, RBC, WBC, and urinalysis were normal. Serum cholesterol was 187 mg. percent, phosphorus 6.5 mg. percent, and alkaline phosphatase 4.0 Bodansky units. The child has continued to be clinically euthyroid. She has grown and developed normally to the present age of ten months. Skeletal maturation was normal at six months of age. The goiter decreased in size progressively and was no longer visible when she was six months old. It is, however, still palpable, and of granular consistency. Radioiodine uptake at ten months was 25 percent.

Discussion

A 40 year old mother, with active thyrotoxicosis, was seen early in her eleventh pregnancy. She had been difficult to treat in the past because of her reluctance to adhere to a therapeutic program. Progressive eye involvement and her responsibilities to her eight children made surgical treatment undesirable. Radioiodine therapy was not considered since it presents a distinct potential hazard to the fetus. Because a rather large dose of propylthiouracil was required to control the patient's thyrotoxicosis, it was considered possible that suppression of the fetal thyroid would occur. It was expected that the infant might be born with a goiter, as she was. Careful evaluation at birth indicated that the child was euthyroid. Laboratory studies at four weeks of age confirmed this impression (protein-bound iodine was normal, as was skeletal maturation). The high radioiodine uptake was interpreted as reflecting the avidity for iodine of an iodine-poor, hyperplastic gland.[11] The child's normal development thus far suggests that there may have been no functional impairment of the thyroid gland. Since a goiter is still palpable, it is planned to observe the child until she is at least two years old.

There is little doubt that the enlarged thyroid of the infant was induced by suppression of thyroid function by propylthiouracil crossing the placenta. Since there is no real evidence that either thyroid hormone or thyrotropic hormone reach the fetus from the maternal circulation, probably the fetal pituitary stimulated the development of the fetal goiter, for thyroid hormone production was suboptimal. It is, of course, possible that the addition of 2 to 3 grains of thyroid to the mother's regime might have prevented the formation of the goiter, although the mechanism by which this would occur is not clear.

Summary

An instance is presented of congenital goiter in an infant born to a mother who required rather large doses of propylthiouracil throughout pregnancy to control her thyrotoxicosis. The infant was euthyroid clinically and had a normal protein-bound iodine, although the radioiodine uptake was markedly increased. The child developed well and at ten months of age has a normal radioiodine uptake, although a small goiter is still palpable.

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Fund Raising and Public Relations in Voluntary Hospitals

Carolyn K. Winters, R.N.

THE SUPPORT OF THE VOLUNTARY HOSPITAL system in the future is indeed a matter of tremendous concern, and everyone connected with hospitals today is obligated to give it considerable thought. The problems confronting the voluntary hospital can only be met by a deeper awareness and a closer concern on the part of all the groups that make up the hospital family: the board of directors, the medical staff, the nursing profession, and hospital personnel. The greater the knowledge which these groups possess about the procedures necessary to maintain an efficient hospital, the better public relations interpreters they will become.

Hospitals today look to the community for a great measure of their support, and there can be no better educators of the public than those who are daily most deeply concerned with the hospital's welfare: with the well-being of its patients, and with maintaining the highest medical standards, both of which are interdependent upon its administrative practices. Dissemination of accurate knowledge about the hospital by these interested groups will not only arouse more public interest, but also will stimulate within the workers themselves a desire to contribute actively to the support of the hospital.

In other words, if each group—the board, the medical staff, and the nursing department—undertook to support that hospital program in which each was most vitally interested, the hospital would have eventually a well-integrated program of fund raising and public relations. The board might well assume the responsibility for raising money to subsidize patients unable to pay their way, the medical staff might undertake an activity to help defray medical education expenses, and the nurses in various ways could raise funds for training of nurses.

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Patterns for money raising have already been established by the splendid women's auxiliaries throughout the country on behalf of the institutions which they represent. The New England Hospital has further developed these activities by the inclusion of professional as well as lay groups as sponsors of fund-raising programs. The "Friends of New England Hospital" conduct a gift, thrift, and coffee shop, and sponsor a Pops concert. The Board of Directors has undertaken to organize a public art exhibit for the non-professional artist. The nurses' alumnae association over the years has sponsored many money-raising projects.

The most recent innovation has been an annual Hospital Birthday Ball, held by the medical staff. This event originally started as a social affair, but now combines sociability with good public relations and fund raising. In addition to the sale of tickets, funds were raised through an anniversary booklet which contained the historical background and other facts about the hospital, and carried many advertisements and lists of sponsors. The Birthday Ball was televised and appeared the next day on two newscasts, which brought a great deal of favorable comment about the hospital. This year the Ball brought together more than 400 friends of New England Hospital and raised more than ten thousand dollars to help defray medical education expenses at our institution. The event will eventually be climaxed by the centennial celebration of this famous institution.

This is just a beginning, and in other years not only will more money be raised and better public relations be established, but also greater interest and knowledge will benefit all of the groups working within the hospital, so that its foundation for the future will be strengthened. Our medical staff should be especially commended for this activity. It is unusual, and means to the hospital administrator that the future of the voluntary hospital system is safe in the hands of the members of the medical profession who will give outside time and effort to supporting the institution of their prime interest.

The History of the New England Hospital

Felicia A. Banas, M.D., F.A.C.S.

THE STORY OF THE NEW ENGLAND HOSPITAL may well begin with the sixth day of September 1829, when Dr. Marie E. Zakrzewska (Zak-shéf-ska) was born at Berlin, Prussia, of an old aristocratic Polish family that traced their lineage to 911 A.D. How, at a tender age, she became interested in medical matters so that she took up the study of medicine is a story in itself. Perhaps the story of the hospital may commence with the date March 13, 1853, when Marie Zakrzewska left her home and her parents to go to America in search of new horizons and new freedoms for women in medicine. One may envision her indomitable courage and self-dedication to ideals as one sees her arriving at Hamburg, only to be forced to wait patiently three weeks for the ice in the river Elbe to liberate the clipper ship for its voyage across the Atlantic. We can only speculate on her thoughts and her emotions as she faced her uncertain future during that voyage of 47 days to New York, where she arrived May 22, 1853.

Though in those days the "accoucheuse," or midwife, had a certain recognition, the practice of medicine and surgery by women was practically a forbidden realm. The women whose yearning and thirst for knowledge impelled them to press for opportunity equal to men were persecuted not only by the intolerant men of the profession but also by a prejudiced and misguided populace as well.

Marie Zakrzewska knew that a medical education was not enough and that the practical work and actual operations and clinical work in a hospital were needed for a proper medical training; but the hospitals were closed to women. Within a year of her arrival, she was in contact with the sisters, Dr. Elizabeth and Dr. Emily Blackwell of New York, the pioneers in opening the medical profession to women. Two years later she received her M.D. degree from Cleveland Medical College (Western Reserve).

Eventually her interests turned to Boston, and, with the aid of progressive men and women of social prominence, the New England Hospital was founded on July 1, 1862, and was incorporated by special act of the legislature on March 12, 1863, while the Civil War was still at its height.

The charter set forth the objects of the new corporation to be:

1. To provide for women medical aid of competent physicians of their own sex
2. To assist educated women in the practical study of medicine.
3. To train nurses for the care of the sick.

The three incorporators were Dr. Marie E. Zakrzewska, Miss Lucy Goddard, and Mrs. Ednah D. Cheney. Throughout the history of the hospital, one finds famous Boston names of prominent men and women as members of the corporation, as directors, as staff consultants, and, in many instances, as philanthropic donors, with a lifetime of service.

In 1872, the first school in America for training nurses was established at the New England Hospital, and Miss Linda Richards became America's first trained graduate nurse. In the course of her long career, Linda Richards founded or headed many other similar schools in this country. In 1877, while in European hospitals, she began her friendship with Florence Nightingale. In 1866, she founded the first training school for nurses in Japan. It was a touching sequel when, at 85 years of age, Linda Richards came back to the New England Hospital, which she loved so well, and in her last illness had the affectionate care of the nurses until she died April 16, 1930.

The New England Hospital is proud of its pioneering, and among its many famous "firsts" are the following:

First in New England to be staffed by women physicians

First in New England to admit women as interns

First to originate a school for training and graduating nurses

First to admit a colored woman for training as a graduate nurse

First to originate the idea of visiting nurses

First to originate social service

First to qualify a woman surgeon as a Fellow of the American College of Surgeons (Dr. Florence Duckering, 1913).

We of the New England Hospital today, still carrying on the traditions of this famous institution, hope that we shall be able to add more "firsts" to the history of New England Hospital.

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The Editors of the JOURNAL are happy to be able to present the following editorial to our readers. It is reprinted by permission of Mrs. Woglom, and *Cancer Research,* where it appeared in 2: 846-850, December '42.

Please!

William H. Woglom, M.D.

"Her pelvis had been injured by being thrown from a motorcycle."

"W—states that he induced the animals to take the hydrocarbon by licking it off a glass rod."

* * *

These gems, which escaped two thoroughly competent editors, are quoted to illustrate the extreme care required for the writing of clear and even reasonably decent English, rather than in derision. Perhaps they should have been discovered in manuscript, but, in the words of the Oriental proverb, even the monkey falls sometimes.

It is not demanded of the scientist that he write elegantly, but that he should try to write well everyone will agree save those few who regard any attempt to do so as silly, not to say effeminate. The curious attitude of this minority was trenchantly declared, upon the founding of a new medical journal, by a prominent investigator who expressed the hope that no "sissy" ideas about good English would prevail. Such a position seemed to his listener deplorable, and after all these years still seems so; for good English is clear English, and surely this is imperative in a scientific article.

Even one whose experience is but small must have been puzzled at the unequal quality of manuscripts submitted by investigators of presumably similar education and social background. Some write clearly and gracefully, earning the thanks of editors thereby, while others express themselves inexpediently or ambiguously. As their very positions guarantee that these latter are neither stupid nor uneducated, there may well exist a group of intelligent and highly educated persons who, nevertheless, are wholly insensitive to the niceties of language, just as there are those who are tone deaf or color blind.

A number of weak, clumsy or actually erroneous constructions soon becomes familiar to the reader of manuscripts, for he meets these old friends every day, and every day he wonders why so few authors acquaint themselves with one of the many invaluable guides to composition.

Never use one word when three will do, appears to be a popular motto. But paper and ink cost something, and typesetting costs more, and so when an author holds a certain influence to account for *this interesting series of secretory phenomena on the part of those cells that comprise the mammary epithelium,* the editor writhes in not so silent anguish, is tempted to substitute *this secretion by the mammary epithelium,* and finally succumbs. The fault is characteristic of non-literary writers, who are apt to put *He was conveyed to his place of residence in an intoxicated condition* for *He was carried home drunk.* So says Professor Robert Malcolm Gay, a friend who these many years has been teaching English composition by oral and by written word.

Or again, when an investigator remarks, as one did recently, "A— had independently reported striking differences in the carcinogenic activity of 1:2:5:6-dibenzanthracene when injected intramuscularly into fowls," he is really saying that A—, when injected intramuscularly into fowls, had independently reported, and so on. In this example the statement is so ridiculous that common sense supplies the true meaning, and the editor has no compunction about inserting the necessary *it is* between *when* and *injected.* But only too often he is not so fortunate, and an inquiry has to be addressed to the author for fear that attemps to improve the unhappy construction or obscure passage may alter the meaning. This correspondence costs his periodical many dollars in the course of a year, and him time, which he resents having to spend conducting a course in elementary English by mail.

Now it is the business of an editor to interpose himself as a filter between author and reader so that the product may be delivered clear, even though not sparkling; and in order that this function may be discharged with the least possible distress to inexperienced authors and pain to the editor, a few paragraphs of advice are offered. Their writer wards off any charge of presumption with the cheerful admission that he has made many blunders, that he

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expects to make many more, and that most of his suggestions have been drawn from such standard guides as Fowler's "Dictionary of Modern English Usage," Woolley's "Handbook of Composition," Fishbein's "Medical Writing," and Webster's "International Dictionary."

Here follow some too, too frequent errors.

The hung participle, a common stumbling block is illustrated by this sentence, recalled from a textbook long since otherwise forgotten.

"Having eaten our lunch, the steamboat departed." Lest it be thought that such a mistake could never occur in a scientific paper a counterpart, recently discovered and corrected, is offered.

"While passing a stomach tube, the trachea was accidently entered."

In and Into.

Methylcholanthrene was injected in mice. Wrong
Methycholanthrene was injected into mice. Right.

Those who have trouble with these two words need only remember this sentence.

The boy burst in the room.

Marked. This appears in almost every manuscript, no doubt because it is so convenient, and saves the trouble of thinking up synonyms. It is objectionable because it is indefinite, including all degrees of qualification from slight to extreme.

A few substitutes, unrecognized by most medical authors, are herein suggested: *appreciable, moderate, considerable, extensive.*

Quite is handled in the same careless way. When it expresses any degree short of totality it becomes a colloquialism and, as such, has no place in a dignified article.

The patient was quite ill. Wrong
The patient was quite motionless. Right.

Very. Authorities say this word has been so overworked that it now tends to weaken, rather than strengthen, a sentence. Thus Fishbein recalls that a prize was once offered through Mr. Franklin P. Adams' column in the New York Tribune for an instance where *very* strengthened the word that it qualified. The only entries were, "Very good, Eddie," and "the Very Reverend Somebody." The use of *very* in speaking or writing, said Mr. Adams, "is a confession of verbal poverty and mental indolence."

There was no pathology in the lungs. Of course not, for pathology is a branch of medicine, not an abnormal condition.

Etiology is like other words ending in *ology,* meaning *the study or science of.* Etiology, unless it is intended to mean the study or science of cause, should be changed to *cause* or *origin.*

Blastogenic. This is coming into use to mean giving rise to tumors, but should not be so employed because it was established long ago to describe Weissmann's theory of blastogenesis. Accordingly, Dr. Esmond R. Long, medical editor of Webster's "International Dictionary," was asked to suggest a substitute. Consultation with his fellow editors led to the decision that *blastogenic* is an erroneous compound of *blastoma,* and the word *blastomatogenic* was proposed, It is hoped, therefore, that contributors to (the JOURNAL) will choose this authorized term in the future.

Butter Yellow is another expression that (the JOURNAL) hopes to see discarded. Dr. Carl Voegtlin and a group of expert chemists associated with him have decided not to allow it in the *Journal of the National Cancer Institute* because it has been applied to four different compounds and hence is ambiguous. Furthermore, considerable anxiety already has been aroused among the lay public on account of the perfectly natural misapprehension that butter yellow is used to color butter. For these reasons the chemical rather than the popular name should be selected.

Nor will that *Journal* make use of the term *procarcinogen.* Since *pro* in biochemistry denotes a precursor, as in *prothrombin,* the preferred word is *cocarcinogen,* and *procarcinogen* will be reserved until such time as the precursors of naturally occurring carcinogens may be discovered. In this respect, too, (the JOURNAL) will follow the example of the *Journal of the National Cancer Institute.*

Cancerogenic and **Tumorigenic** not only grate on the ear, but also are examples of a word tossed together from two languages. The derivation of *carcinogenic,* on the other hand, is beyond reproach, and it is a much more euphonious term besides.

A contributor who was asked to substitute *carcinogenic* in his manuscript took the suggestion in good part and replied that the prospective elimination of the automobile from American life had robbed him of the most shining example of a widely accepted bastard word. Of course he was right. There are many such terms in current use and one should not be priggish in the matter. But one may prefer a word that is both etymologically correct and more melodious without being branded an insufferable purist.

Tenses. Writers often skip lightheartedly from one tense to another, even in the same paragraph, and not infrequently to the confusion of the reader. Furthermore, there appears to be no good reason for describing experiments in the past tense and microscopic morphology in the present, though this is a common practice. Perhaps the safest rule is to keep to the past tense in all descriptive matter.

Due to is a problem. Fowler says that this expression is used by the illiterate as though it had passed,

like *owing to,* into a mere compound preposition, whereas *due,* like ordinary participles and adjectives, must be attached to a noun and not to a notion extracted from a sentence. Webster's "International Dictionary" defines *due* as: "owing . . . (*to* something) . . . as, his death was due to pneumonia; often erroneously used in the phrase *due to,* meaning because of, modifying a verb in the manner of a compound preposition; as, he failed *due* to lack of study."

Hypothecate. This does not mean to make a hypothesis, as some seem to think, but to deposit as security.

Individual should be employed only to designate one of a specific group.

This individual complained of epigastric pain. Wrong

In his speech he referred to several individuals in the audience. Right.

Lymph glands. These structures are in no sense glands, and ought to be called *lymph nodes.*

Polynuclear is a wholly inaccurate abbreviation, for the polymorphonuclear leukocyte has nuclei of many shapes; not many nuclei.

Operated animals. One can operate an automobile, but not a patient or animal.

Tumor mass. *Mass* is an unnecessary addition, the tumor itself being a mass. In the expression *tumor tissue,* also, *tissue* is usually superfluous.

All of. This is a colloquialism; the *of* is redundant. Write *all the animals,* not *all* of *the animals.*

Claim refers only to belongings. A man may claim his hat, but should not claim that he observed leukemia in mice injected with a carcinogen.

Proven, an archaic and irregular form originating in the Scottish law courts, is a special favorite of medical writers. Authority frowns on it, however, and would like to see it replaced by the regular form, *proved.*

Malignant degeneration. Do not substitute this term for *malignant transformation* which, God knows, is not a degeneration. In pathology *degeneration* implies inactivation.

Malignancy. This is an abstract noun, and should not be made synonymous with *malignant tumor* or *malignant disease.*

Biopsy means neither the removal of tissue nor the piece extirpated, but examination of this piece, usually under the microscope.

X-ray is used when referring to the apparatus employed for taking pictures by roentgen ray. A roentgenogram means a picture produced directly on special film by roentgen rays. The photofluorogram is a picture taken by a camera on photographic film of the image produced on a glass screen by roentgen rays.

Human. Write *cancer in the human subject,* not *cancer in humans. Human* is really an adjective; as a noun it is not sanctioned by the best usage.

Affect and **Effect** are often erroneously interchanged. No one but an editor will believe this, yet it is so.

Question as to. Fowler calls this an ugly and needless formula.

The question arises as to whether the tumors were caused by the injections. Wrong.

The question arises whether the tumors were caused by the injections. Right.

As large, or larger, than is a common fallacy. A moment's reflection would show that when the little afterthought and its enclosing commas have been deleted, *as large, or larger, than a plum* becomes *as large than a plum,* which is manifestly absurd. The correct expression is *as large as, or larger than, a plum.* This paragraph does not condone the careless habit of comparing the size of a lesion with that of some familiar object. Actual dimensions, expressed in the metric system, are, of course, much to be preferred.

Different than enjoys an enormous popularity; nevertheless, it is wrong. *Different from* is right.

Verbs and **subjects.** Everyone who has been to school should have learned that a verb and its subject must agree in number. But when a verb is widely separated from a singular subject, and one or more plural nouns intervene, the eye is frequently deceived into accepting the plural form. Here is a recently discovered example.

"The amount of estrogenic hormones produced in virgin females of various stocks are the result of strain differences." Obviously *are* should be *is.*

Disagreement in number often follows an unnecessary economy in the use of verbs. Thus:

"The various fractions were moistened with sesame oil and the suspension injected into mice."

Was should have been inserted between *suspension* and *injected.* This mistake was discovered five times in two manuscripts that were nearly perfect.

Data is a plural noun. Never, *never,* NEVER write *the data is.*

Only must be treated with care, for its position in a sentence determines the whole meaning. *He only injected the mice with methylcholanthrene* might mean that he, alone, injected the mice, in which case *only* should have been set off by commas. Or it might signify that he injected the compound but did not administer this in some other way as well. *He injected the mice only with methylcholanthrene* implies either that he injected the mice, but not the rats, say, or that he gave the mice nothing but methylcholanthrene. He *injected the mice*

with methylcholanthrene only is a perfectly clear statement.

Also is an equally tricky word, as anyone may see who will take the trouble to substitute it for *only* in the preceding sentences.

The above results. Here *above* is wrongly employed as an adjective. Instead write *the results described above.*

With and By frequently cause a dilemma, in which this sentence may be of some help: *The old gentleman was killed by his son with an ax.* Thus *by* refers to the actor, and *with* to the instrument.

Solutions. Zenker's solution, Ringer's solution, and so forth, are preferable to *Zenker* and *Ringer.*

Which and That. These are so difficult to use correctly that Fowler devotes several pages to them. In an amusing subsection entitled "Elegant Variation" he says, "I was surprised many years ago when a . . . well known writer gave me his notion of the relation between *which & that:* When it struck him that there was too much *which* about, he resorted to *that* for a relief . . . of the unskilled writer's method it would be a true enough account."

The present writer was deeply shamed by this passage, since he himself had been practicing "elegant variation" for years without even knowing it. He learned then and there, in brief, that *which* is appropriate to nondefining and *that* to defining clauses, as Fowler's two examples will show.

"The river, which here is tidal, is dangerous."

"The river that flows through London is the Thames."

To bring the argument nearer home, consider these two sentences.

The sarcoma, which arises in connective tissue, is a malignant tumor.

The sarcoma that is completely extirpated will not recur.

Woolley offers a useful rule for determining whether a given clause is nonrestrictive (that is, nondefining) or restrictive. If the main assertion of the sentence retains its meaning when the clause is omitted, the clause is nonrestrictive. Evidently, then, *which arises in connective tissue* is a nonrestrictive clause and *which* is suitable for it.

But if omission changes the sense of the main assertion, the clause is restrictive. Hence, *that is completely extirpated* must be a restrictive (or defining) clause appropriate to *that.*

The question has been gone into at some length because it is not so purely academic as it may seem at first sight. Indeed, a passage may be entirely obscured by the misuse of *which* and *that.*

At autopsy. *At autopsy the liver was enlarged.* The truth is that it was enlarged before autopsy, therefore accuracy requires *found* or its equivalent between *was* and *enlarged.*

It may be mentioned in passing that *necropsy,* or *postmortem examination,* is regarded by careful writers as preferable to *autopsy.*

Asceptic, for *aseptic,* is occasionally seen in barber shops and scientific journals.

Commas. Often these seem to have been inserted whenever the typist happened to rest her fingers for a moment, as they are distributed generously and in accordance with no known plan. The rules for the use of this punctuation mark are so many that the amateur writer may well be excused from learning them, but at least he can attempt to employ commas in such a way as to make his meaning clear.

For instance, one should be placed before the *and* in what Woolley calls the *a, b,* and *c* form. Its omission, he contends, is illogical, for in the sentence "There were blue, green and red flags," *green* and *red* are coupled and apparently set apart, as a pair, from *blue;* whereas the intention is to make all three adjectives equally distinct.

One encounters not infrequently a statement like this: *Dibenzanthracene, methylcholanthrene, and benzpyrene, in addition to several other carcinogens, were injected.*

Were the methylcholanthrene and benzpyrene administered separately, or not? The reader has no way of knowing. If they were, a comma should be placed after methylcholanthrene. If not, the sentence should be recast to make clear exactly what was done.

The comma under discussion, it is interesting to know, is called by New York newspapermen, in affectionate badinage, the F.P.A. comma, after Mr. Franklin P. Adams, who has fought so long and so manfully for its retention.

Omissions. Articles have been published in which the word *tumor* appeared throughout with never a hint as to the nature of the growth, and others that did not specify the kind of animal.

Sentence construction. Sometimes a paper is entirely clear, but annoying because it consists of one short sentence after another, dumped down before the no longer gentle reader like a load of bricks. An example from such a source follows.

The animals were kept in wooden boxes. They were bedded in shavings. No more than six animals were kept in a box. X and Y have reported cancer in the liver in this strain. The food was mouse pellets. Water was freely given.

Since the manuscript is not now available the passage has been reproduced from memory, but the writer solemnly asseverates that it was virtually as given, even to the totally unrelated statement. The

remedy for all this is to combine some of the sentences by inserting connectives—*hence, and, accordingly, on the other hand, however,* and the like. The reader can then progress easily, as in crossing a brook by a bridge, instead of having to leap from one steppingstone to the next.

Repetition. Or again, a word may be repeated with maddening persistence. In manuscripts submitted on the subject of cancer research, *tumor* is naturally the most overworked, appearing in some papers again and again, as though *carcinoma, sarcoma, neoplasm, malignant disease, growth, or new growth,* did not exist.

Such distressing misadventures suggest that little care has been taken in preparing the manuscript. Those who pride themselves on writing well are accustomed to make several revisions, clarifying obscure passages, transposing sentences or paragraphs to more suitable positions, eliminating redundancies, and so on. No writer should ever forget the French author who sent a copy of his latest book to a friend, with the apologetic little note: "If I had had more time I could have made it shorter."

Often the fourth or fifth draft, which it is fondly hoped will be the final one, is set aside for a while, and he to whom this is a first experience will be amazed at the number of improvements that can still be effected. It will be found helpful, also, to read this version aloud, for frequently the ear will discover faults that the eye has not seen.

A clear and fluent presentation of facts and their interpretation is more important than most investigators seem to realize. A friend of the writer, charged with the responsibility of directing an electrical engineering laboratory, once remarked that his young assistants who could not write clearly did not think clearly, and in the end had to be discharged. Lest he be thought too exacting, witness this passage, quoted by Fishbein (J.A.M.A., 119: 1239, 1942) from Sir Robert Hutchinson.

". . . . It may be contended in reply to all this that the style of medical writing (s) is not of much importance because these are read primarily for their matter. Unquestionably this is too superficial a view, for, as Allbutt said, 'The man of science ought best to know that style and matter can no more be dissociated than skin and bone; but if we write clumsily, loosely or disjointedly our thoughts are accordingly.' "

THE A.W.H. IN HAITI

(In Haiti, the American Women's Hospitals cooperates with the Baptist Mission and the government in medical relief work. The following is an excerpt from a report dated April 8, 1955, received from Millicent Engel, R.N., who is connected with this co-operative service.—ESTHER P. LOVEJOY, M.D., *Chairman,* Committee on Medical Service—American Women's Hospitals)

"There is still typhoid in the South as an aftermath of the hurricane. The government said they would give free vaccine if I would inoculate the people. Sunday in church it was announced that we would do the children Monday afternoon and the adults Wednesday.

"Monday morning we were very busy with dispensary patients, but felt we could still do the afternoon's work. By 2 p.m., there was crowd of 1,500 outside the doors. We worked steadily until 6 p.m. with three doing inoculations, but got only 680 done. Because of the pushing crowds, we didn't dare put out kerosene lamps for fear of their being pushed over, and we do not have electricity.

"Tuesday, after the clinic session, I went on a home delivery, but the woman had placenta previa, and the only presenting part I could feel was the shoulder, which was very high. Thus, I took her to the hospital in Cap Haitien, which was 20 miles away over very rough road, through a river, and over a high winding mountain. There they were very kind, took my word for everything, I did a cesarean immediately, and got a 10 pound boy. The mother went into shock, had to have several stimulants and transfusions, but is in fair condition now. I got to bed at 2 a.m.

"At 6 a.m., there was already a great crowd at the hospital, and so we decided to start right away. By 9 a.m. it was no longer possible to control the crowd, and so we called the police to help us. One of the helpers was knocked down and walked on when she tried to get in. She wasn't hurt much, but certainly did bleed. All the locks on the doors are now loose and the frames weren't strong enough to hold back the pushing crowds. At first the policeman would hold them back with his rifle, but they soon lost their fear of that. Finally, he got mad, hunted up a big switch, and spent the rest of the time going from door to door whipping them back. I'm sure that it must have hurt them, but as soon as he would leave for the next door, they would all come back to resume their pushing. With four people inoculating, we did 1,530, and only stopped then because we ran out of vaccine; of course I wasn't sorry. We are going through the whole thing again on Monday."

World Health Organization

THE FIELD OF PRESENT KNOWLEDGE about poliomyelitis, including the prospect for its control, is reviewed in a 400 page monograph just published by the World Health Organization in Geneva, containing papers written by 17 polio specialists representing seven countries and WHO's staff. The studies cover the history of the disease, first reported in epidemic form a little over a century ago; the present world-wide extent of polio, caused by three known types of virus; and the search for weapons against the disease.

Polio occurs throughout the world and every human being is sooner or later subject to infection by one or another of the three known types of polio virus, "Brunhilde," "Lansing," and "Leon." These viruses are unbelievably small, measuring between 10 and 30 millionths of a millimeter.

Infection by the polio virus takes a number of forms varying from a non-apparent infection to severe paralytic illness. Indeed, it is only in a very small number of cases that the infection develops into the acute and easily recognizable paralytic form of the disease. The paralytic form of the disease is the exception rather than the rule, and strikes principally those who have not acquired immunity, or a sufficient degree of immunity.

The monograph concludes with a list of precautions to be taken in epidemic periods both to reduce the spread of infection and to minimize the number of paralytic cases: frequent washing of hands; protection of food from flies and thorough washing of fruit and uncooked vegetables; avoidance of close contact with members of a family in which a case of polio has occurred recently; caution in treating all cases of fever; avoidance of overexertion; closing down of unchlorinated swimming pools; and, until more information is available, avoidance where possible of operations for the removal of tonsils or adenoids, and suspension of vaccination campaigns and intra-muscular injections of an irritant character.

"Poliomyelitis," No. 26 in WHO's Monograph Series, is available at $8 per copy from the Columbia University Press, 2960 Broadway, New York 27, N.Y., or may be ordered through the United Nations Bookshop.

* * *

The World Health Assembly is the legislative organ of WHO. It is made up of government representatives from WHO member states. The Assembly is also attended by observers from the United Nations and other international bodies, as well as from medical, scientific, and other associations which have official relations with WHO.

On May 10, 1955, the Eighth World Health Assembly opened in the city of Mexico, Ciudad Universitaria. It was expected to last three weeks and was attended by some 300 delegates from all parts of the world. The meetings were open to the press and the public.

The programme of work of the Health Assembly is heavy: there were 70 major items on the agenda which fall under two main headings: 1) review of current health work assisted by WHO and 2) determining the WHO programme and budget for 1956. Proposals for new activities, and especially work in the field of atomic energy, were examined.

The World Health Assembly met in plenary sessions as well as in two main committees of the whole: the Committee on Programme and Budget and the Committee on Administration, Finance and Legal Matters. The World Health Assembly also held technical discussions on the subject of special public health problems of rural areas, and delegates visited rural health centres in different areas of Mexico.

* * *

A detailed inventory of the equipment needed to set up a medical school is now available as the result of a joint undertaking by the World Health Organization and the United Nations Educational, Scientific and Cultural Organization.

This reference manual is intended chiefly for use in new medical schools. It is the latest in a series of inventories of apparatus and materials for teaching science at all levels which was begun by UNESCO in 1949 to promote the introduction of suitable science teaching into schools of war-damaged or underdeveloped regions.

The book contains lists of equipment used in the instruction of medical students in eight subjects: anatomy, bacteriology, biochemistry, histology, pathology, pharmacology, physiology, and hygiene and public health.

"Inventories of Apparatus and Materials for Teaching Science," Part 5 (Medical Sciences) of Volume III, is available at all UNESCO Sales Agents at $2.75 a copy; in the United States, it can be obtained from the Columbia University Press, 2960 Broadway, New York 27, New York, and the United Nations Bookshop.

THIRTY-SECOND ANNUAL MEETING OF AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

At the Thirty-Second Annual Meeting of the American Orthopsychiatric Association, held in Chicago, February 28 to March 2, 1955, a most stimulating and greatly varied program was presented. Since one of the functions of this association is to "unite and provide a common meeting ground for those engaged in the study and treatment of problems of human behavior," experts in the fields of psychiatry, clinical psychology, and psychiatric social work were the speakers on such subjects as Juvenile Delinquency (for example, "Modification in Treatment of Anti-Social Psychopathology in Adolescents"); "Childhood Schizophrenia, Its Recognition, Description and Treatment"; "School Phobia"; and "A Re-evaluation of Projective Theory," showing the value of projective testing as a clinical adjunct to treatment.

Two of the seminars attended were quite forward looking. One of these, "Disturbances of Mothering," was especially challenging, particularly the last paper entitled "Mothering and Fathering in our Culture," emphasizing the fact that, in the process of developing a more permissive attitude toward the child, we have robbed the father, not only of his autocratically authoritative role, but also of much of his ego strength. At the same time, the devaluation of homemaking has pushed the woman out of the home to compete with men in the business world, which may overburden and harm her, thus decreasing her value as wife and mother. These social attitudes, with the resulting change in role, confuse the child.

The other symposium, "Roads to Human Understanding on the Industrial Front," pointed out the need of developing psychiatric care as a measure to prevent the loss of man hours, as well as to increase better interpersonal relationships. The employee through job insecurity and dependency ties, is more amenable to a supportive type of psychotherapy, whereas, the employer shies off from that which may threaten his prestige and control. A dogmatic view, such as "Manager has got to be strict," may be a barrier which prevents him from seeing the real needs of the employees. When these needs are ignored, an underground note of hostility may develop and permeate an entire department and pave the way for an agitator to capture that group. Educational programs and psychological evaluations are beneficial for a long term program, but the immediate need is to have a well trained psychiatrist available to any person in an industrial plant where such service is needed. Such a consultant would function not as one telling tales back to the employer, or vice versa, but as a friend who has the freedom of frank questioning and who will give full reassurance that the records will be kept private. As the psychiatrist's role is better clarified and his services better understood, so then will his value to the company increase and effect a lessening of tension between management and labor.

—*Reported by* Katherine W. Wright, M.D.

ESTHER E. BARTLETT, M.D.

Guest Editor

We welcome Dr. Esther E. Bartlett—Guest Editor—chief of the Department of Anesthesiology at the New England Hospital, Boston, Massachusetts.

Through Dr. Bartlett's efforts, the Department of Anesthesiology at New England Hospital has full approval for two years residency training (with an anesthesia scholarship fund) for women physicians desiring to enter this specialty.

Because of her, too, an unusual department of education is in process at New England Hospital, through which house officers are given unique and highly personalized supervision and training.

From her associates at New England Hospital, we learn that Dr. Bartlett combines the rare attributes of a scholarly mind, top-ranking professional ability in her specialty, and selflessness toward that profession; together with the adaptability to make practical application of those qualities for immediate needs and the vision for long-range planning for the advancement of women in medicine.

American Medical Women's Association

PRESIDENT'S MESSAGE

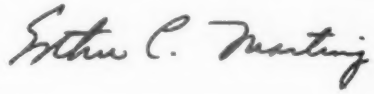
ANOTHER JUNE IS HERE. Another year has passed for the Association and it is again time for a new President and a new set of officers to take over. It is with deep modesty that I assume the responsibility of the Presidency of this organization. I am tremendously proud to have been chosen by you superior women. I realize, with all humility, that my own deficits are numerous, and earnestly pray that I will be able to fill this important office with some degree of efficiency.

My job has been made much easier by the arduous efforts of my predecessors, and I wish them to know that I am deeply grateful. I shall need the counsel of past officers and I shall need the help of every member of the Association. I want your suggestions and ideas and, of course, your help throughout the year. After all, this is your Association and the activities of the Association are your business. The officers merely serve to carry out your wishes to the best of their abilities.

My regard for the ideals and purposes of the Association has multiplied many times since I first attended a Board Meeting as a committee member some seven years ago. I now understand more fully the motivating force behind the fine women doctors who freely give of their efforts and abilities to obtain a secure place for women in medicine. These women do not need this service for themselves because they have already attained important places among their fellow doctors, but they work because they believe in women as physicians and wish to help other women obtain and maintain a high standard of excellence in their chosen field. Elizabeth Blackwell and many other courageous pioneer women medics were spurned and rejected. The woman doctor of today is respected and readily accepted. The AMWA is not an organization of suffragettes but rather a group of women doctors banded together to assure that qualified women can obtain a good medical education and use it to the fullest advantage. We want our places among the best.

This year's program will stress the various facets of Industrial Medicine, an infant specialty in the field of medicine. Last year we learned much about the uses of atomic energy. That knowledge will fuse intimately with our study of Industrial Medicine. The public has already begun to bombard the physicians with questions about the effects of radiation. "What will the atom bomb tests do to this country?" "How will they affect the people and especially the children?" "What measures should be taken for protection?" "What are you, doctor, going to do to help us?" Both speculation and fact-finding studies have gone on since the bombing of Hiroshima, and although much has been learned, there remains a vast amount still undiscovered. More and more is being learned about the potentialities of atomic radiation and the possibilities of producing an entirely new group of disorders of the human body. New types of radioactive materials and new techniques are being developed for use in the treatment of certain diseases. The field of the use of atomic energy as a source of power for our highly mechanized civilization has scarcely been scratched. Developments are coming along at a breath-taking pace.

All of this means that radioactive materials must be mined and refined or artifically produced. More and more people will be in contact with them. The understanding of the effects of these materials, the prevention of harmful exposure to them, and the treatment of damage caused by them constitute a new challenging field for the physician in Industrial Medicine. This new field is virgin territory. We, you and I, and the rest of the physicians, are the explorers. Let us not be left behind. Let us not be like Lot's wife who was turned to salt because she was looking back. We must keep our sights before us, and we must advance and progress as our profession demands. Let us be proud that we are women. Let us be proud that we are doctors and have a vital place under today's sun.



SOCIAL SECURITY FOR THE DOCTOR

Old Age and Survivor's Insurance, a part of the Social Security system, is an arrangement by which employed persons have withheld from their salaries a small percent which is augmented by an equal amount from the employer and submitted to the Federal Government as a tax. Self-employed persons pay a similar amount direct to the Federal Government, and all receive up to $85 a month for life after the age of 65, unless they continue to earn more than an alloted amount. In this case, they and their employers must continue to pay the tax.

It was anticipated by its planners that the system would permit reduction of another branch of Social Security, Federal Old Age Assistance. However, the expenditure in this branch has increased greatly, since only 30 percent of the 13.5 million aged persons in the United States benefit from OASI. Actually, only about 45 percent of the aged are eligible for OASI benefits. The two and a half or three million aged persons receiving benefits at the end of 1952 had already received 24 times as much money as they and their employers had contributed in taxes, and actuarial estimates indicated that they would eventually receive 50 times as much as had been contributed by and for them. Presumably, contributions and taxes paid by those now young are carrying this load.

The term "insurance" in relation to this program is obviously misused. Insurance is legally defined as a contract. Old Age and Survivor's Insurance cannot be considered a contract since the "premiums" or contributions are compulsory, and one of the parties (Congress) can change any phase of the rules, from the amounts of money involved to the eligibility requirements, at any time. These changes, thus far, have been in the direction of bringing more and more of the population under the system, thus increasing alarmingly the ratio of benefits paid to contributions collected. This trend, as the electorate continues to increase in average age, is expected to continue.

Plans to include physicians along with about three million other citizens not now covered by OASI, were made by Mrs. Oveta Culp Hobby's committee without the help of any physicians except government employees. The AMA Washington office was not consulted nor were the members of Mrs. Hobby's own medical advisory committee, chosen from a list supplied by the AMA, invited to attend the committee meetings. The House Ways and Means Committee last year, in considering the proposals of the new Social Security regulations, voted first to include all doctors in the OASI system. A few days later, however, after a storm of protest from medical men throughout the country, they voted to leave them all out. When the measure reached the Senate Finance Committee, it was decided to extend Social Security to doctors on a voluntary basis, but a few days later this committee, too, reconsidered and voted to exclude physicians after Social Security experts expressed the opinion that only "bad risks" would join.

A poll conducted by *Medical Economics* magazine indicated that the physicians of the United States are almost equally divided on the question of their own participation in the system. In favor of inclusion of doctors in OASI were 42 percent of the youngest age group queried and 52 percent of the oldest, 49 percent of specialists and 41 percent of general practitioners, 45 percent of independent private practitioners and 60 percent of salaried doctors, and 68 percent of doctors practicing in large cities and 28 percent of small town doctors. Women physicians were almost as reluctant to subscribe to the plan as small town doctors, being only 36 percent in favor of it. The income levels of the pro and con groups were not significantly different. The reasons given by doctors who were opposed to extension of OASI to medical men reflected distrust of governmental efficiency in handling claims and money and avoiding waste, disapproval of a system believed to be another instance of "deficit spending" since it cannot support itself, and resentment of the compulsory aspects which many frankly called socialistic. They expressed concern that Congress, by changing again the criteria of eligibility, might make it impossible for most physicians to benefit, and pointed out that many physicians die before 65 and most of those living longer continue to practice. The most vehement felt that such a system subsidized inefficiency and penalized ability, that it was improper for physicians to oppose socialized medicine and welcome "socialized pensions," that regimentation is the inevitable price of this type of security, and that doctors would become "wards of the government." Many of those in favor of the measure were equally cynical, however, not only

about the Government but also about the ability of their medical colleagues to manage their own retirement programs. They felt that doctors were being called into service repeatedly, preventing them from carrying out a savings plan for retirement, that there was no reason to discriminate against doctors by excluding them, and that many of those voicing opposition had arranged through salaried jobs to be covered by OASI anyway. It was pointed out that Social Security is a better bargain than private insurance, the benefits being equivalent to a $25,000 annuity.

It seems evident that those opposed to Social Security are opposed to it as a matter of political philosophy, that they deplore its existence for all groups and not just for doctors, and that their objection is to government compulsion and mediation and not to pension and retirement plans generally. Those expressing themselves in favor of Social Security either do not subscribe to these principles at all or feel there is no use in retaining them.

The Federal Government is clearly ready to take over from the young its responsibility and privilege for caring for the old. Perhaps it is easier for elderly people to accept this support mediated through and made compulsory by a government bureau. Undoubtedly, the failure of many of the young to acknowledge personal responsibility in this respect has made such a system inevitable. Obviously, also, a part of the individual's privilege and responsibility to plan for his own old age has been taken over by the Federal Government. The grasshopper and the ant no longer exist as extremes in a large segment of our society, for the hand of the Federal Government is unobtrusively guiding the grasshopper into more ant-like ways and, as part of his work is done for him by the Federal Government, the ant is becoming somewhat more frivolous and relaxed than heretofore. A more realistic comparison in terms of human behavior is that between man's desire to improve his lot by making and taking advantage of opportunity, even at some risk, and his desire for security. The great depression which inspired the present Social Security measures has apparently become more rather than less fearsome as it recedes into the past, its hardships increasingly more unthinkable in the prosperous present. This fear, fostered by political expediency, has pushed the pendulum farther toward a substantial compulsory redistribution of wealth than at any time in the history of our country.

There is no doubt that it is man's weakness and not his strength that seeks security and which Social Security measures are taken to protect. Yet it is clear, also, that since we all have been and will be at some time weak and unable to help ourselves, our desire for security partakes of the wisdom of the ant.

Probably the almost equal division of opinion among doctors as a group about their wishes to be included or excluded from the Social Security plan has been true of every other group of American citizens previously made a part of the plan. That doctors have been articulate in relation to this measure reflects, perhaps, their literacy level as well as their strong sense of individual independence. The measure is sure to be brought up again and additional pressure brought to bear to include physicians under OASI provisions.

—Elizabeth A. McGrew, M.D.
Legislative Committee

NEWS FROM THE BRANCHES

Branch Sixteen, Pittsburgh

At the time of the State Medical Society Meeting at Pittsburgh in September 1955, the Allegheny County Medical Women's Association is sponsoring a luncheon for the medical women attending the meeting.

The luncheon is to be held at 12:30 p.m. on Thursday, September 22, 1955, at the Duquesne Club, 325 Sixth Avenue, Pittsburgh. All women physicians of the state of Pennsylvania and other women physicians attending the meeting are invited. Reservations are being received by Dorothy Klenke Nash, M.D., 4136 Bigelow Boulevard, Pittsburgh 13, Pennsylvania.

Branch Thirty-Nine, Boston

The fall meeting of Branch Thirty-Nine was a buffet supper served at the home of Dr. Martha Brunner-Orne. Colored pictures of Europe were shown by Dr. Brunner-Orne's husband, Dr. Frank Orne, and by Dr. Freida Por. There was an attendance of 31 members and guests.

A tea was given to honor Dr. Marian W. Ropes. This was the winter meeting, and Dr. Ropes was honored as the Branch choice for Medical Woman of the Year. Among the 41 guests present were Dr. Lucy Lee from the Philippines, now at Massachusetts Memorial Hospital; Dr. Elli Trolle of Denmark, now at the Children's Medical Center, Boston; and Dr. Anne Cann Evans from England, also at Children's Medical Center.

The annual meeting was held on May 18, 1955. This was a luncheon meeting; officers were elected and business matters completed. Dr. Camille Mermod, President of the AMWA, was a special guest.

The membership from Branch Thirty-Nine is 67, with 6 new members.

New Members—1955

CALIFORNIA

Esther K. Yiu, M.D.—2968 Telegraph Avenue, Oakland 9, *China 23, '40*

Chin Hsin Gin, M.D.—1445 Stockton Street, San Francisco, *Tung Te Medical School, '47*

Celia T. Suso, M.D.—15 Farallones Street, San Francisco, *Mex. 1, '37,* GP

GEORGIA

B. B. Shannon Gallaher, M.D.—Medical College of Georgia, Augusta, *Pa. 9, '50,* I

KENTUCKY

Corazon S. Bishop, M.D.—Wm. Booth Hospital, Covington, *Phil. 1, '50,* I

ILLINOIS

Victoria L. Elliot, M.D.—2800 Milwaukee, Chicago 18, *Ill. 9, '43,* GP

Bernice E. Gotaas, M.D.—2320 W. Warren Blvd., Chicago, *Ill. 11, '51*

Asna Hirschmann, M.D.—4180 Marine Drive Chicago 13, *Ger. 16 '49,* Pd

Charlotte Herman Kerr, M.D.—712 S. Marshfield Avenue, Chicago 12, *Ill. 11, '48,* ObG

Virginia E. Kvinge, M.D.—720 S. Michigan Blvd., Chicago 5, *Ill. 6, '52*

Bernice Perdziak, M.D.—2322 N. Commonwealth Avenue, Chicago 14, *Ill. 43, '48*

Patricia K. Roberts, M.D.—853 W. Barry Avenue, Chicago 14, *Jap. 16, 44,* I.

Bertha P. Schmulevitz. M.D. — 3333 Washington Blvd., Chicago, *Ill. 43, '17,* GP

Virginia R. Sorum, M.D.—1321 Winnemac Avenue, Chicago 40, *Pa. 7, '49,* N

Lillian Barsky, M.D.—1110 Nichols Lane, Maywood, *Ill. 11, '49,* Pd

IOWA

Jean Box Glissman, M.D.—1068-42nd Street, Des Moines, *Ia. 4, '49,* PN

MARYLAND

Edith Slockbower, M.D. — 1101 Elbank Avenue, Baltimore 12, *Ia. 4, '45,* P

Betty May Young, M.D. — 3706 North Charles Street, Baltimore 18, *Vt. 2, '48,* OLR

MASSACHUSETTS

Angela C. Duffy, M.D.—6 Hubbard Street, Concord, *Mass. 7, '50,* Pd

Claire F. Ryder, M.D.—Harvard School of Medicine, 1 Shattuck Street. Boston, *Mass. 7, '44,* PH

Hedwig H. Holzer, M.D.—P.O. Box 631, Taunton, *Aus. 1, '27,* Pd

MICHIGAN

Emily Ethelene Jones Crockett, M.D.—7263 American Avenue, Detroit 10, *D.C. 4, '45,* ObG

MONTANA

Margaret A. Reed, M.D.—518 Hickory, Anaconda, *Neb. 6, '51*

NEW YORK

Anna Samuelson, M.D.—1455 Sheridan Avenue, New York 57, *N.Y. 9, '30,* C

OHIO

Anne M. Alstott, M.D.—311 So. 5th Street, Ironton, *O. 41, '28,* GP

Evelyn Frances Golomb, M.D.—Sunny Acres Hospital, Cleveland 22, *Pa. 7, '38.* Tub.

Lucy O. Oxley, M.D.—611 West 8th Street, Cincinnati 3, *O. 41, '35,* GP and Cancer

PENNSYLVANIA

Katharine O. Elsom, M.D. — Old Gulph Road, Haverford, *Pa. 1, '30*

Rose R. Mikelberg, M.D. — 1709 Spruce Street, Philadelphia, *Neb. 5, '27,* Pd

TEXAS

Anna Bath Connell, M.D.—420 Montrose, Lufkin, *Tex. 4, '49*

PHILIPPINES

Pacita R. Feliciano, M.D., M.P.H.—1151 C. Singalong, Manila, *Phil. 2, '47,* Pd

Associate Members

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Phyllis E. Buckley, M.D.—Georgetown, Colorado.

Cleora Handel, M.D. — 484 Dartmouth Avenue, Buffalo, N.Y.

Bettina Clarice Hilman, M.D. — 1610 Audubon Street, New Orleans, La.

Lillian L. Imperi, M.D. (Mrs. W. J. Rumbros)—1435 Broadway, Ann Arbor, Mich.

E. J. Lappat, M.D.—c/o Denver General Hospital, Denver, Colo.

Marliese Ly Lehtmets, M.D. — Lake in the Hills, Algonquin, Ill.

Anna Loeffler, M.D. — 7121 East 4th Avenue, Denver, Colo.

Renee Bennett O'Sullivan, M.D.—249 Dudley Road, Newton Centre, Mass.

Neldagae Smith, M.D.—17 S.E. 35, Oklahoma City, Okla.

Ellen Song, M.D.—1993 California Avenue, Wahiawa, Oahu, T. of Hawaii.

Barbara von Schmidt, M.D. — 2828 High Street, Oakland, Calif.

Taisja Zarska, M.D. — 9373 E. Jefferson, Detroit, Mich.

Ann Marie Travis, M.D.—4008 Avenue Q, Birmingham, Ala.

Margaret Wiedenbauer, M.D.—Strum, Wisconsin.

Alice Ruth Williams, M.D.—201 South 21st Street, Council Bluffs, Ia.

Junior Members

Medical College of Alabama

Janice Cailleteau—800 20th Street South, Birmingham, Ala.

Betty Jean Vaughn—1569 N. 20th Street, Birmingham, Ala.

University of Arkansas

Jeanne Rae Bonar—University of Arkansas, School of Medicine, Little Rock, Ark.

University of California

Joyce Erickson — 2828 21st Street, San Francisco, Calif.

University of Southern California

Lailee Bakhtian Tecimer—613 N. Canon Drive, Los Angeles, Calif.

Stanford University School of Medicine

Norma Lee Boone—1520 Marrin Avenue, Porterville, Calif.

University of Colorado

Alice R. Bishop—855 Jackson, Denver, Colorado

Marcia Frances Curry — 4200 E. 9th Avenue, Denver, Colorado

Yvonne Marcel Johnson — 1163 Lincoln Place, Boulder, Colorado

Jacqueline Ruth Jorgensen — 1134 Vine Street, Denver, Colorado

Betty Jean Horner—No. 29 Colorado Blvd. Apts., 768 Colorado Blvd., Denver, Colorado

Elaine P. Shoelzel—376 Dexter St., Denver, Colo.

Yale University School of Medicine

Rosalie A. Burns—Yale School of Medicine, New Haven, Conn.

Northwestern University

Faye Spencer Anderson—7455 N. Greeview, Apt. 317, Chicago 26, Ill.

Dorothy Irving Beebe — 629 Deming Place, Chicago, Ill.

Pearl Yuin-Tai Shen—Apt. 508, 240 East Delaware Place, Chicago, Ill.

Joan Kalaine Short — 710 Lake Shore Drive, Chicago, Ill.

University of Illinois

Mallie L. Barclay—1900 W. Polk Street, Chicago, Illinois

Maija Elizabeth Katlaps—5327 W. Belmont Avenue, Chicago, Illinois

Maralyn Ellis Toman—4422 Drexel Blvd., Chicago, Illinois

Stritch School of Medicine, Loyola University

Gina Phillips Moran — 1344 Thorndale Avenue, Chicago, Illinois

Mary T. Stanczak—10126 So. Bell Avenue, Chicago, Illinois

University of Kansas

Marjorie Cates — 1240 Nebraska Avenue, Kansas City, Kansas

Tulane University School of Medicine

Gloria Josephine Garner—Tulane University School of Medicine, New Orleans, La.

Elizabeth Jane Morphy—2200 Palmer Avenue, New Orleans, La.

Ann Sproul—Box 98, Sedan, Kansas

Louisiana State University School of Medicine

Evelyn Bobette Carney—Box 256, Louisiana State University Medical School, New Orleans, La.

Frankie Mae Slay—212 Marais Street, New Orleans, Louisiana.

Monica F. Sorum—1029 Orleans St., New Orleans, Louisiana.

Paula Allen Walden—Box 211, Louisiana State University Medical School, New Orleans, La.

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Ann Adkins Browder—800 North Broadway, Baltimore, Md.

University of Michigan

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University of Mississippi School of Medicine

Mary Lane Burkes—Box 608, University, Miss.

St. Louis University School of Medicine

Rosemary E. Schmidt—St. Mary's Hospital, Clayton, Missouri

Donita B. Sullivan—7829 Marlette Road, Marlette, Michigan

University of Nebraska

Elizabeth A. Johnson—521 So. 35th Street, Omaha, Nebraska

Vivita Krievs—4416 Farnum, Omaha, Nebraska

University of Buffalo

Barbara Jane Hultman—98 Blaine Avenue, Buffalo, New York

State University of New York

Beatrice Kaplan — 30 Hartley Avenue, Mount Vernon, New York

Ingeborg Blass Shaffer—210 Congress Street, Brooklyn, New York

Columbia University College of Physicians and Surgeons

Tenki S. Tenduf-La—Bard Hall, 50 Haven Avenue, New York, N.Y.

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Toni Gloria Wallace—63 Wadsworth Terrace, New York, N.Y.

University of Oregon

Lila J. Pasnick — 1507 No. 20th Street, Tacoma, Washington

Catherine A. Poole—University of Oregon Medical School, Portland, Oregon

Woman's Medical College of Pennsylvania

Dixie F. Arahaki—3028 Midvale Avenue, Philadelphia, Pa.

Mary Ann Bartusis — 435 W. Bringhurst Street, Philadelphia, Pa.

Nina L. Bencich—Woman's Medical College of Pa., Philadelphia, Pa.

Marilyn Schnur Brotman—12 Essex Street, Irvington, New Jersey

Mary Chang—Woman's Medical College of Pennsylvania, Philadelphia, Pa.

Eleanor Cohn—519 King Street, Philadelphia, Pa.

Janet Cuttner—3518 Ainslie Street, Philadelphia, Pennsylvania.

Carol M. Denig—519 W. King Street, Apt. C-23, Philadelphia, Pa.

Marguerite G. Deutch—Woman's Medical College of Pennsylvania, Philadelphia, Pa.

Floy C. Helwig—Woman's Medical College of Pennsylanvia, Philadelphia, Pa.

Gloria M. Hing — Women's Medical College of Pennsylvania, Philadelphia, Pa.

Joyce Howell — 472 Winona Street, Philadelphia, Pennsylvania.

Nancy C. Lamancusa — 3613 Fox Street, Philadelphia, Pa.

Margaret Marie Mazzucco — 4443 Morris Street, Philadelphia, Pa.

Elinor Mikelberg—1709 Spruce Street, Philadelphia, Pennsylvania.

Sister Michael Marie — Ravenhill Academy, Germantown, Philadelphia, Pa.

Joan Peterson—519 King Street, Apt. 43, Philadelphia, Pa.

Lily Shirlen Poon—3613 Fox Street, Philadelphia, Pennsylvania.

Mary Resinski—2605 E. Clearfield Street, Philadelphia, Pa.

Nancy Ellis Rogers—Woman's Medical College of Pennsylvania, Philadelphia, Pa.

Rita K. Sacks—7658 Williams Way, Elkins Park, Pennsylvania.

Hagalyn H. Seay—5417 Pulaski Avenue, Philadelphia, Pa.

Ellen Scheiner—4443 Morris Street, Philadelphia, Pennsylvania.

Estherina Shems—3021 Queen Lane, Philadelphia, Pennsylvania.

Nancy J. Stubbe—3412 Warden Drive, Philadelphia, Pa.

University of Pennsylvania

Sondra E. Golomb—1525 Lardner Street, Philadelphia, Pa.

Temple University School of Medicine

Lois J. Dilks—139 Ashby Road, Upper Darby, Pa.

Susan M. Stormer—1409 W. Ontario Street, Philadelphia, Pa.

Vanderbilt University School of Medicine

Alice Louise Hackney, (Mrs. L. B. Altstatt)—c/o Vanderbilt Medical School, Nashville, Tenn.

Baylor University College of Medicine

Hope Willard — Baylor Medical School, Houston, Texas

University of Vermont College of Medicine

Valery W. Yandow—295 Maple Street, Burlington, Vermont.

Medical College of Virginia

Anne Smith Goldston — 7401 Three Chopt Road, Richmond, Virginia

University of Washington

B. Kathleen Adams—4754 16th NE, Seattle, Wash.

Loretta A. Snyder—4754 16th NE, Seattle, Wash.

University of Wisconsin Medical School

Eleanor Julin—417 Sterling Ct., Madison, Wisc.

McGill University Faculty of Medicine

Carole Joyce Barry—c/o Mrs. Keane, 3569 Rue de Sainte Famille, Montreal P. Q. Canada

Opportunities for Women in Medicine

INDUSTRIAL MEDICINE

Public Health and Hospital Administration

The University of Michigan School of Public Health, beginning with the current academic year, is offering courses leading to the degree of Master of Public Health (Industrial Health). Requirements for the degree are similar to those for other M.P.H. candidates with six additional course hours in the specialty. In some instances special sections of the courses required for all M.P.H. candidates have been set up for the industrial health students. During the current year, five students are enrolled for the degree.

A related degree has also been approved by the University Board of Regents. A program leading to a Master's degree in hospital administration will be offered for the first time in the academic year 1955-1956. The program will be centered in the School of Business Administration and will have an advisory committee made up of the deans, or their representatives, of the Schools of Public Health, Medicine, and Business Administration. S. J. Axelrod, M.D., associate professor of public health economics, is the representative of the School of Public Health. Other schools of public health training hospital administrators are those of the Universities of California, Minnesota, and Pittsburgh, and of Columbia and Yale Universities.

Fellowships

The Institute of Industrial Health of the University of Cincinnati has made available a limited number of fellowships for qualified candidates who wish to pursue graduate work in industrial medicine. Registered physicians, graduates of an approved medical school with at least two years of training in an accredited hospital are eligible. Private practice or service in the Armed Forces may be substituted for one year of training.

The course of instruction consists of two years of intensive training in industrial medicine, followed by one year of practical experience under adequate supervision in industry. Candidates who complete the course of study satisfactorily are awarded the degree of Doctor of Science in Industrial Medicine.

The fellowship stipends vary from $3,000 to $3,600 in the first year depending on marital status, and $3,400 to $4,000 in the second year. In the third year, the candidate will be compensated by the industry in which he is completing his training.

Additional information from Institute of Industrial Health, College of Medicine, Cincinnati 19.

Course

A full-time eight week comprehensive course in industrial medicine for physicians will be given in the Post-Graduate Medical School of New York University-Bellevue Medical Center commencing Monday, September 26, 1955.

Among the subjects being offered to physicians are: organization, administration, and economics of an industrial medical department; the practice of preventive and constructive medicine in industry; the clinical aspects of occupational diseases; industrial injuries and the elements of safety programs; and toxicology and industrial hygiene for the physician. Opportunities will be provided for attendance at medical, surgical, and clinical pathologic conferences during the course.

Applications should be sent to the Dean, NYU Post-Graduate Medical School, New York 16, N.Y. Tuition is $250.

RESIDENCIES

The Veterans Administration Hospital, Lyons, N.J., has available one to three year residencies in psychiatry that are fully accredited by the American Board of Psychiatry and Neurology. The training program consists of lectures, conferences, and seminars under the direction of the department of psychiatry, New York Medical College, and offers intensive training, both intramurally and through rotation, in special hospitals and clinics in the adjacent area. There is, in addition, an extensive series of guest lecturers as well as an annual institute at the hospital. Training may commence at any time during the year.

* * *

The Indian Medical Association requests offers from recognized hospitals for residency posts in all specialties for physicians from India (men and women), specially selected for graduate training in hospitals in the United States. These physicians will have a good command of spoken and written English. The hospitals must be approved by the U.S. State Department for the exchange-visitor program. Interested hospitals are requested to communicate by air mail with the Honorary Secretary, Indian Medical Association, "Hanging Bridge," Daryaganj, Delhi 7, India, giving offers of posts, terms of appointment, and so forth, including maintenance, stipend, and also the allotted number for the exchange-visitor program.

SCHOLARSHIPS

The Foundation of the American Society of Plastic and Reconstructive Surgery announces its 1955 scholarship contests. In the junior classification, the contest is restricted to residents in training and to plastic surgeons who have been in practice no longer than five years. Essayists must be residents of the American continent, British dominions, or Western Europe. Two prizes—$1,000 and a three month scholarship, and $750 and a three month scholarship—are offered for essays of about 5,000 words that are the result of some original research, either clinical or experimental, in plastic and reconstructive surgery. Papers that have been previously published even in part will not be accepted. All essays must be submitted in quadruplicate, and in English only, with no indication of the writer's name or institutional affiliation. An additional envelope shall include the contestant's name, address, and institutional affiliation, with details of professional training and percentage of practice in plastic surgery. Character references must be forwarded by two leading plastic surgeons from the applicant's country. Contestants in the senior classification must have been in active practice of plastic and reconstructive surgery for more than five years. A silver plaque or certificate of honorable mention is offered for a winning essay in this classification. Requirements are the same as those for the junior classification. Manuscripts will not be accepted by the award committee after July 1. The winning essays must be presented in person at the annual meeting of the American Society of Plastic and Reconstructive Surgery in Atlantic City, Sept. 25 to 30. Information may be had by writing to the Award Committee, c/o the Foundation of the American Society of Plastic and Reconstructive Surgery, Inc., 30 Central Park South, New York 19.

* * *

The New England Hospital has recently established scholarships for women during their graduate medical training: one of the scholarships is for intern training; the other two are for residency training in obstetrics and anesthesiology.

* * *

The International College of Surgeons, through the generosity of the Woman's Auxiliary of the United States and Canadian sections, is offering a scholarship to a young Canadian or American surgeon who wishes to study abroad. This is not a traveling fellowship. The physician selected will be expected to spend at least 10 months of the year as a resident or fellow in a teaching center in one of the countries of Europe or South America. The scholarship will be in the amount of $3,000 to pay for transportation and living expenses for 12 months. Details may be obtained from the Scholarship Committee, International College of Surgeons, 1516 Lake Shore Dr., Chicago 10.

MEETING

The Eastern Division Regional Meeting of the International College of Surgeons, will be held on Cape Cod, Chatham, Massachusetts, July 1 to 4, 1955. The registration fee is $5, with no charge for residents and interns. For further information write: Beacon Travel Service, 145 Tremont St., Boston 11, Massachusetts.

RESEARCH FELLOWSHIPS

The Surgeon General of the Public Health Service has announced a predoctorate research fellowship program at the National Institutes of Health. These research fellowships in health, medical sciences, and related fields will be available to successful candidates with Bachelor's or Master's degrees or equivalent training. Stipends vary from $1,400 to $1,800, with a $350 allowance for spouse and each dependent child. Basic tuition and certain travel allowances will be paid. Application may be made at any time. Information and application blanks may be obtained from: Research Fellowships Branch, Division of Research Grants, National Institutes of Health, Bethesda 14, Md.

* * *

Two Ciba research fellowships are available to qualified applicants in the division of obstetrics and gynecology, University of Tennessee College of Medicine, Memphis. The fellowships are a part of a four year residency leading toward a Master of Science degree in obstetrics and gynecology. After the first year, the fellowship year, during which successful applicants will work in basic research, they are expected to proceed into the clinical residency. The fellowships, which begin July 1, carry a stipend of $150 per month in addition to living quarters, food, and uniforms. Applications may be made to the Chief of the Division of Obstetrics and Gynecology, University of Tennessee College of Medicine, 894 Madison Ave., Memphis, Tenn.

HEART DISEASE RESEARCH

A group of 114 awards just approved provides support for 3 Career Investigators, 50 Established Investigators, and 61 Research Fellows of the American Heart Association, who will carry out their studies in 23 states, the District of Columbia, and three foreign countries—England, The Philippines, and Denmark.

The Career Investigatorship provides unrestricted, lifetime research support to scientists of outstanding ability. Originated by the American

Heart Association in 1951, it remains the only position of its kind maintained by a voluntary health agency. The Career Investigatorship provides $25,000 per year to cover the stipend of the Career Investigator and to furnish him with technical assistance, equipment, and supplies.

Established Investigatorships are awarded to highly qualified scientists for periods of from one to five years, subject to annual review, and provide stipends of from $6,000 to $9,000 per year. Research Fellowships, awarded for one or two years period, are intended to help younger scientists train for research careers under experienced supervision. They carry stipends of from $3,500 to $5,500 per year.

For further information write: American Heart Association, 44 East 23rd Street, New York 10.

AVIATION MEDICINE

The Harvard School of Public Health is offering for the first time graduate training in aviation medicine during the current academic year. The program leads to a degree of Master of Public Health. It meets the requirements of the American Board of Preventive Medicine for one year of graduate training in the basic sciences related to aviation medicine.

The board, which recently certified aviation medicine as a medical specialty, requires two years each of graduate study in preventive medicine and aviation medicine, following an internship, of residency in aviation medical practice, and of unsupervised practice in aviation medicine, in addition to regular and frequent participation in aerial flight.

The year at Harvard consists of a special seminar in aviation medicine in each of the four quarters. The seminars include discussions of practical problems, from the human aspect, of high altitude operations, ventilation, temperature, humidity, control of insects and air-borne diseases, noxious gases, noise, vibration, acceleration and motion, cockpit and control cabins, passenger accommodations, and psychological factors involved in the selection of airmen.

In the first class at the School of Public Health, 15 Air Force aviation medical officers are enrolled. Those who plan to enter medical services of aircraft manufacturing companies and civil airlines are admitted as well as representatives of the military service.

CONTESTS AND AWARDS

The Society of Cosmetic Chemists, 2 E. 63rd St., New York 21, has instituted an award of $1,000 for "that recent contribution to the scientific literature which is judged to be of the greatest potential value to the improvement of cosmetic technology." The literature review committee invites submission of papers published in original and in abstract form between Jan. 1, 1953, and Dec. 31, 1954. Papers published as theses, which have not appeared in any periodical, are also eligible.

* * *

Nominations are now being accepted for the fourth Kimble Methodology Research Award, which will be presented in November through the generosity of the Kimble Glassware Division of Owens-Illinois Co. The award, $500 and a suitably inscribed plaque, is administered by committees of the Conference of State and Provincial Public Health Laboratory Directors. To be eligible for consideration for nomination in 1955, the work should have been completed since Jan. 1, 1950, and should be accompanied by a reprint or a summary with bibliography and a statement of the considerations that justified the recommendation of the study; candidates should be from the United States, its territories, or Canada; and the work should be either a fundamental contribution that serves as a base line for development of diagnostic methods that fall within the province of the public health laboratory or the adaptation of a fundamental contribution to make it of use in a diagnostic laboratory. Nominations received after May 30 will not be considered for the Kimble Methodology Research Award for 1955 but will be considered for nomination in 1956; providing the work was completed since Jan. 1, 1951. Nominations should be sent to M. Scherago, D.V.M., Chairman, Nominating Committee, Kimble Methodology Research Award, Department of Bacteriology, University of Kentucky, Lexington.

* * *

The tenth annual Schering Award competition for medical students has been announced. Its aim is to encourage medical writing and exploration of current research literature.

Titles of three subjects on which American and Canadian students are invited to submit papers this year are: Current Concepts in the Management of Osteoporosis; Prevention and Treatment of Blood Transfusion Reactions; and Recent Trends in the Clinical Use of Adrenocortical Steroids.

Both a $500 first prize and a second one of $250 will be awarded for each of the three subjects. Outstanding authorities in each field will select the winners. Special recognition in the form of a professional gift will be given each student submitting a meritorious paper.

Deadline for entry forms specifying the choice of title is July 1, 1955. Manuscripts should be mailed

not later than October 1. Students may compete individually or co-operatively in teams.

Information and instructions for the award competition are available from the Schering Award Committee, 60 Orange Street, Bloomfield, N.J.

* * * *

The American College of Gastroenterology, in co-operation with the Ames Company of Elkhart, Indiana, takes pleasure in announcing the establishment of the Ames Award contest for the best papers in gastroenterology. There will be three classes of awards as follows:

Fellows or residents in gastroenterology. First prize, $250, a certificate of merit, and a one year subscription to *The American Journal of Gastroenterology*, official publication of the American College of Gastroenterology. Second Prize, $50, a certificate of merit, and a one year subscription to *The American Journal of Gastroenterology*.

First or second year interns. First prize, $250, a certificate of merit, and a one year subscription to *The American Journal of Gastroenterology*. Second prize, $50, a certificate of merit, and a one year subscription to *The Journal*.

For the best paper published in *The American Journal of Gastroenterology*, during the twelve months ending June 30, 1955, for which no prize has been previously awarded, $100.

All papers submitted must represent original work in gastroenterology, must not have been previously published except for abstracts or short preliminary reports, and must not have been previously presented at any national meetings. The contents of the papers can be clinical or basic science. Clinical papers must not be case records, but controlled clinical work. The length of paper is no criterion for originality or value.

All entries for the 1955 prizes, with the exception of those already published in *The American Journal of Gastroenterology*, must be typewritten in English, double-spaced on one side of the paper, and submitted in six copies.

The winning entries will be selected by the Research Committee of the American College of Gastroenterology and the awards will be made at the annual convention banquet of the College, to be held in Chicago in October 1955. All papers selected for awards become the property of the American College of Gastroenterology and the decision of the judges will be final. Should none of the papers submitted meet the standards set by the committee, the committee reserves the right to withhold the making of any award.

The recipients of the first prizes will present their paper in person at the annual meeting.

All unpublished entries must be received no later than September 1, 1955, and should be addressed to the Research Committee, American College of Gastroenterology, 33 West 60th St., New York 23.

COURSE

A short intensive course on the laboratory diagnosis and pathology of parasitic infections will be presented August 15 to 27, 1955, at the Louisiana State University School of Medicine in New Orleans, La.

The course is designed primarily for pathologists and technicians. However, general practitioners, internists, pediatricians, gastroenterologists, and physicians engaged in the practice of public health and tropical medicine who are interested in the laboratory diagnosis of parasitic infections are welcome to attend. The instruction and training will be of assistance to pathologists who are preparing for board examinations, to pathologists and physicians who are responsible for the diagnosis of parasitic infections in their laboratories, and to technologists engaged in this specialty.

The course will include lectures, extensive demonstrations, films, and supervised individual laboratory study. Emphasis will be placed upon the practical aspects of laboratory diagnosis of common parasitic infections, including training in stool examination and stool concentration technics. Abundant material from patients with parasitic diseases endemic in this area will be available for examination. Comprehensive slide sets containing parasitic organisms in tissue sections will be studied. Library facilities are available.

Registrants should bring their microscopes, equipped with mechanical stages, and their microscope lamps. A limited number of places will be available. The fee for the course is $50.

Persons interested in attending this course may write to: Dr. Clyde Swartzwelder, Department of Microbiology, Louisiana State University School of Medicine, 1542 Tulane Avenue, New Orleans 12, Louisiana.

FULBRIGHT TRAVEL GRANTS

United States citizens who can qualify as "advanced scholars" and who occupy senior teaching positions in medical schools and departments of preventive medicine may be interested in travel grants which may be available for sabbatical leaves in other countries, especially Great Britain. Persons interested should communicate with Reginald M. Atwater, M.D., Executive Secretary, APHA, 1790 Broadway, New York 19, New York.

ALBUM OF WOMEN IN MEDICINE

LETITIA DOUGLAS ADAMS, M.D.

DR. LETITIA DOUGLAS ADAMS is a graduate of Tufts Medical School. She interned at the New England Hospital for Women and Children, Boston, Massachusetts. Surgery attracted her from the start of her career, and she studied and worked under Dr. Clara J. Alexander. After completing her surgical training, she became assistant in surgery at the New England Hospital, then became chief of her surgical service, and, finally, chief of the surgical department. During this time, she was also chairman of the staff. Dr. Adams, a Fellow of the American College of Surgeons, is a skilled obstetrician and medical practitioner, as well as an outstanding surgeon. Hers is indeed a rare gift, for she is one of those who are naturally so endowed with skill, humanity, and idealism that she is able to care for the whole person. Her type of accomplishment is so unusual that today one finds references to this ideal. Physicians may profitably copy Dr. Adams' happy combination of traits; her skillful technique seasoned with kindness, understanding, and unselfishness.

There are a host of medical friends, grateful patients, and admirers to give Dr. Adams the inner satisfaction of having accomplished a purpose. Her very rich experiences have taken her through many fascinating highways and byways of medicine. Her care of patients included delivering babies, caring for mothers, and practicing general surgery and medicine. She knew every facet of the care of the sick. All this took place before specialties divided the human into separate spheres. She watched the rise and fall of new methods and techniques and kept those that helped her patients. Her panorama of medical experience is wide, colorful, and full of drama.

Here is a great surgeon who has demonstrated her will and ability to help others. Her special qualities or great skill, faithfulness, and tenderness to her patients, her generosity in sharing her knowledge and wisdom with her colleagues, are appreciated by many friends, patients, and associates. Indeed, many surgeons in the New England Hospital today are indebted to her for their basic surgical training and their subsequent success. As one who has gained tremendously from knowing Dr. Adams, I think of her primarily as a healer, therefore, a great exponent of our profession.

After retiring from active practice, Dr. Adams did not retire from helping others. She is a busy and valued director of the New England Hospital, and, drawing from her rich experience, she is able to guide her nonmedical directors, who are devoted and desirous of promoting the very best for this institution.

The rewards in medicine are many. Dr. Adams must feel the satisfaction and spiritual compensation she has known so well in the physician-patient relationship.

—MIRIAM KATZEFF, M.D.

ESTHER E. BARTLETT, M.D.

FOR THE PAST FIFTEEN YEARS, Dr. Esther E. Bartlett has been chief of the Department of Anesthesiology at the New England Hospital, Boston, Massachusetts, where she has established a well-organized, functioning department.

Dr. Bartlett was graduated from Sargent College and from the University of Wisconsin, where she received not only her B.A., but also her M.A. (in physiology) and M.D. degrees. After serving her internship at the Wisconsin General Hospital, Dr. Bartlett studied anesthesia under Dr. Ralph M. Waters, the father of anesthesiology, and then accepted a fellowship in her chosen field at the Chicago Lying-In Hospital. She returned to Massachusetts in 1937, and spent her residency at the New England Hospital in clinical research in anesthesia.

An outstanding physician in her specialty, Dr. Bartlett typifies a splendid combination of teacher and physician both by her training and present-day practice of medicine.

Because of her untiring efforts, the Department of Anesthesiology at the New England Hospital has a full approval for two years residency training, with an anesthesia scholarship fund for women physicians desiring to enter this specialty. Dr. Bartlett's interest lies primarily in furthering the education of women physicians at the New England Hospital, and she found a kindred interest in Mrs. Oakes Ames, past president of the board of directors. Through their combined efforts, an unusual department of education has been established. The plans include an educational department through which courtesy, consulting, and active staff members give the house officers unique and highly personalized attention. The daily conferences, development of a house officers' club, and specialized university courses, as well as scholarship funds in various departments are a few of the educational features in this New England Hospital which was founded and chartered for the purpose of maintaining educational opportunities for the advancement and aid of women in medicine.

Although Dr. Bartlett carries full professional responsibilities, she nontheless manages the time to be an expert organic gardener at her home in Quincy. It is to her we look not only for professional guidance, but also for advice on all of our home gardening problems.

Dr. Bartlett's goal in life is to achieve, in a small general hospital, the ideal of university calibre medicine taught to house officers intending to go into the private practice of medicine.

Through all the years of trials and tribulations in organizing her department and acting as chairman of the committee on education, Dr. Bartlett has maintained her forefathers' spirit of pioneering as Dr. Josiah Bartlett did when he signed the Declaration of Independence.

—ANN P. D. MANTON, M.D.

News of Women in Medicine

BLACKWELL AWARDS OF THE NEW YORK INFIRMARY

THE SEVENTH ANNUAL CEREMONY of Award of the Elizabeth Blackwell Citation was held at the New York Infirmary, Fifteenth Street and Stuyvesant Park East, Sunday, January 23, 1955. Three women physicians received the honor: Dr. Katharine Dodge Brownell, Dr. Phyllis Greenacre, and Dr. Lilian Cook Warnshuis.

Dr. Brownell, director of the Lower East Side Rheumatic Fever Project in the Department of Preventive Medicine at the New York University College of Medicine and assistant professor of clinical pediatrics, is also a Master in Public Health. During World War II, under her maiden name, Katharine Dodge, she was deputy medical director for the United Nations Relief and Rehabilitation Administration, and worked in Greece during the most dangerous period of the civil war. She travelled throughout the country, helping sick and starving villagers who were out of reach of the Allied supply lines. She brought British supplies to ELAS hospitals herself, and accomplished miracles of assistance to the Greeks. Before the war, she carried on investigations in the problem of rheumatic fever, practiced pediatrics, and taught in New York University College of Medicine.

The New York Infirmary hereby makes this citation of Dr. Katharine Dodge Brownell in recognition of her contribution to medical knowledge in the fields of pediatrics and public health. The recorded facts of an individual's accomplishments rarely do him justice. Dr. Brownell has led a productive, useful, and exciting life in medicine. Several institutions can look on her with pride as one of their graduates. Her pre-college years were spent at the Winsor School, in Boston; her Bachelor's degree was received from Vassar, and her degree of Doctor of Medicine from Johns Hopkins University. She also studied at London University, and later received the degree of Master in Public Health from Columbia University. Following her internship, Dr. Brownell became assistant in pediatrics at Bellevue Hospital, and progressed to the position of assistant professor of clinical pediatrics at New York University College of Medicine. Her work at Bellevue Hospital was concerned chiefly with heart disease in children. In association with Dr. Lucy Sutton, she carried on investigations in the problem of rheumatic fever. These studies were outstanding, and stand as a monument to the efforts of these two women physicians. When World War II came, Dr. Brownell distinguished herself, not only as a physician, but also as a woman. She first worked with the United States Committee for the Care of European Children, and was then appointed a senior surgeon in the Public Health Service. Most of her work was in Greece, and she was repeatedly mentioned for its superlative quality. Dr. Dodge, as she was then, went into Greece, in her capacity as deputy medical director for the United Nations Relief and Rehabilitation Administration, in November 1944, and worked through the period of the civil war, which was a time of great danger. She travelled around the country, helping sick and starving villagers who were out of reach of the Allied supply lines. She displayed the qualities that have distinguished her medical life: energy, initiative, and indomitability. The British, who were already in Greece, were not particularly enthusiastic about having a woman medical officer on the job. Dr. Dodge set out on one of her trips to evaluate the needs of the people and was forced back to Athens by the civil war. This was an exceedingly dangerous period. Shooting was apt to break out at any time, and several of Dr. Dodge's companions were wounded. As *Time* magazine recorded in the issue of April 16, 1945, "The Athens hospitals, with no food, coal, telephone, medical supplies, or even water, were desperate. Many patients were phonies, with fake bandages and concealed tommy guns. Filth and refuse, including an occasional dead body or amputated limb, lay untouched on the ground below the hospital windows. Dr. Dodge brought British supplies to ELAS hospitals herself. Her woman assistant spotted a coal heap, took a taxi out, and shovelled it full. Dr. Dodge got the hospital staffs to throw out the fake patients and take care of the real ones. She got the Greeks to clean up their hospitals, delouse, scrub, and bury the dead and the refuse." A correspondent who saw "the Dodge Dynamo" in action said, "I saw her restore order in the midst of a hundred Greek Red Cross workers who wanted higher pay, and then persuade a British brigadier to put all his transport at her disposal to carry food to a village above the snow line, . . . all in twenty minutes." On returning to the United States, Dr. Dodge was married to George Brownell. She studied for and received her degree of Master in Public Health. She is now director of the Lower East Side Rheumatic Fever Project in the Department of Preventive Medicine at the New York University College of Medicine and assistant professor of clinical pediatrics. She is also associate visiting physician on the pediatric service at Bellevue Hospital. Dr. Brownell, like Dr. Elizabeth Blackwell, has always refused to be discouraged, and has used her great talents and abilities for the benefit of others. The New York Infirmary is proud to confer the Elizabeth Blackwell Award on Dr. Katharine Dodge Brownell.

Dr. Phyllis Greenacre is a psychiatrist. She has received other honors for her outstanding work in this field, and is the author of a book, "Trauma, Growth and Personality" (Norton). She was formerly consultant at the Westchester County Department of Child Welfare, has been for some years professor of clinical psychiatry at Cornell Medical College, and is attending psychiatrist at New York Hospital. She is on the faculty and was formerly president, New York Psychoanalytic Institute.

The New York Infirmary hereby makes this citation of Dr. Phyllis Greenacre in recognition of her achievements in the field of psychiatry. Dr. Greenacre was born in Chicago, Illinois. She attended school there and was graduated from the University of Chicago, and received her medical education at Rush Medical College. She was awarded the Rush Medal, a significant honor. She served as an intern and assistant resident psychiatrist at Johns Hopkins Hospital, and later became assistant instructor and associate psychiatrist at that hospital. She is a Diplomate of the American Board

ELIZABETH BLACKWELL CITATIONS AT THE NEW YORK INFIRMARY
Left to Right: Mrs. Frank A. Vanderlip, Dr. Lilian Cook Warnshuis, Dr. Phyllis Greenacre, and Dr. Katherine Dodge Brownell.

of Psychiatry and Neurology, and her present appointments include professor of clinical psychiatry, Cornell Medical College, and attending psychiatrist, New York Hospital. She is on the faculty of the New York Psychoanalytic Institute. She has had numerous honors: Phi Beta Kappa, Alpha Omega Alpha, has been president of the New York Psychoanalytic Institute, and Freud lecturer. Dr. Greenacre is richly endowed with a sensitive, sympathetic understanding, and keen interest in children. She has emphasized and displayed this talent in her clinico-analytic studies relating to developmental problems in early infancy. Her book, "Trauma, Growth and Personality" (Norton), is an important contribution to the science of psychiatry. In these days of anxiety, economic change, and painful insecurity, we are willingly or unwillingly thrown back upon our own resources. We must search out our own weaknesses and strengths, examine our motives, and try to discover our true selves. We must strive, in an environment which manifests disintegration, to achieve integration. Many of us cannot manage alone, and must receive the help that can be given by the psychiatrist, preferably one who adds to skill the precious qualities of sympathy, patience, and understanding. In other words, the competent psychiatrist must have not only technical training, and a background of valuable experience, but also a sensitive, critical, and sympathetic comprehension of the conflicts and ambitions and qualities of each patient. We believe Dr. Greenacre to be this kind of psychiatrist. The New York Infirmary is proud to confer the Elizabeth Blackwell Award on Dr. Phyllis Greenacre.

Dr. Lilian Cook Warnshuis, at present medical officer at the Connecticut College for Women, spent 15 years in India, working with her husband, the Rev. John Warnshuis, and taking care of sick Indians, both at the hospitals in Vellore and Magdanapalee, and in their homes in villages or deep in the interior. While in India, Dr. Warnshuis was vice-principal and professor of medicine at the Vellore Medical School for Women, and also examiner in medicine for the Madras Government Medical College.

The New York Infirmary hereby makes this citation of Dr. Lilian Cook Warnshuis in recognition of her accomplishment in the teaching and practice of internal medicine in this country and in India. Dr. Warnshuis has had an exciting, interesting, and useful life in medicine. Dr. Warnshuis was educated in Scotland. She graduated from the Inverness Royal Academy and then was a licentiate of arts at Scotland College. She studied in Germany for a year and received her degree in medicine from Edinburgh University. After graduating from medical school, she was the house surgeon at the Derbyshire Sick Children's Hospital. From there she went to the Vellore Hospital in India. She spent 15 years taking care of sick Indians in the interior of that country. She was physician to the Magdanapalee Hospital for four years, visiting physician to the Vellore Medical College, and examiner in medicine for the Madras Government Medical College. She was very active in teaching and was vice-principal and professor of medicine at the Vellore Medical School for Women. In 1931, she and her husband, The Rev. John Warnshuis, returned to the United States. Here, she was associated with Bellevue Hospital and New York University College of Medicine. She was a clinical assistant and then assistant visiting physician on the Third

Medical Division of Bellevue Hospital, and she was appointed an assistant clinical professor of medicine at New York University College of Medicine. Her private practice was in Staten Island where she was the first woman appointed to the Staten Island Hospital. Staten Island was a rather hard place for a woman doctor to break ground, but Dr. Warnshuis did this and gained the admiration and respect of her colleagues. At present, she is physician to the Connecticut College for Women in New London, Connecticut. All of this is but the recitation of appointments. Where Dr. Warnshuis is concerned, the character of her work, the affection she inspires among her colleagues and patients, her extraordinary astuteness in diagnosing disease, and the understanding care with which she treats her patients have increased her medical stature. In her teaching at New York University, the students found her stimulating and a delightful person with whom to discuss cases. Dr. Warnshuis' Scottish accent could often be heard in the clinic when she was particularly aroused about some case which had been handled incorrectly or in a sloppy manner by a student. Without raising her voice, she managed to convey to the young men and women students of medicine not only how to take a history and how to write a physical examination but also, and this is quite a necessary part of medicine, how to use language to express these findings. An important part of Dr. Warnshuis' life was that spent in India with her husband, the Rev. John Warnshuis. It was during World War I that she went to India to join her future husband. The ship that she was on was sunk by a submarine in the Mediterranean Sea. Of the 700 passengers, barely 200 escaped with their lives. Dr. Warnshuis' description of what took place was a magnificent example of understatement. The story is relayed to us through one of her associates to whom she related it. Dr. Warnshuis said that they had just come up from lunch and she was standing on the deck, when, without warning, there was a terrific explosion and the ship literally broke in half. The passengers jumped into the sea and Dr. Warnshuis remarked rather dryly that she has had no particular interest for sea bathing since then. There were, as usual in those days, too few lifeboats. Dr. Warnshuis swam around among the wreckage for a while and finally a lifeboat, filled to capacity, came within her grasp. In telling this part of the story, she has said with no affectation "I saw that they were more than crowded so I naturally did not expect them to take me in." However, they did manage to squeeze her on board for which we are all very grateful. Accomplishment in medicine is not measured only by the number of important positions a person may hold, by the number of papers he may publish or by his research. Rather, the real physician is the one who imparts to his patients a feeling of confidence and dependability; to his students a stimulating, critical, and understanding point of view; and to his colleagues a realization of complete integrity combined with sound common sense and good medical knowledge. Dr. Warnshuis has these qualities, and in her medical life has developed them so that whoever is fortunate enough to be associated with her profits by this association and in turn becomes a more considerate, more critical, and better informed physician, dedicated, as all physicians should be, to the care of the patient. The New York Infirmary is proud to confer the Elizabeth Blackwell Award on Dr. Lilian Cook Warnshuis.

* * *

An interesting feature of the Elizabeth Blackwell award ceremony was the presentation to the New York Infirmary of a facsimile of Dr. Elizabeth Blackwell's diploma granting her the degree of Doctor of Medicine from Geneva Medical School, Geneva, New York, in 1849. Dr. Madge C. L. McGuinness, director of physical medicine at Misericordia Hospital, and member of the New York Infirmary Alumnae and former alumnae trustee, and Dr. Margaret Wallace Ferguson have made a gift to the Infirmary of this diploma framed as nearly as possible as the original. Dr. McGuinness made the speech of presentation and said that Dr. Elizabeth Blackwell had given her original diploma to Queen Margaret's College at the University of Glasgow, Scotland, in gratitude for her happy association with that institution.

DISTRICT OF COLUMBIA. The George Washington University Medical Society held a recent meeting in the Medical Society's auditorium. Dr. Charlotte Donlan was the principal speaker; her subject, "The Combined Use of Radiation Therapy and Intra-Arterial Aureomycin in the Treatment of Cervical Cancer."

Dr. June Carol Shafer assisted in the teaching program on radiation during the thirteenth annual meeting of the American Academy of Dermatology and Syphilology in Chicago. She presented a paper on "Prevention of Radiation Injuries."

New York Infirmary

Dr. Elise L'Esperance, who, with her sister May Strang, established in the N.Y. Infirmary, 1932, the world's first cancer prevention clinic, has been reappointed consulting director of the Strang department for the coming year.

Dr. Frances Bogatko is the new director of the Strang Tumor Clinic. She is also attending physician at Strang Clinic, Memorial Hospital; instructor at Cornell University College of Medicine; and member of the N.Y. Cancer Research Institute.

Dr. Irja Widenius is the new director of the Department of Obstetrics. She is attending gynecologist and member of the medical board of Midtown Hospital.

Dr. A. Parks McCombs is the new director of the Department of Medicine, and Dr. Marion Manter has been appointed director emeritus of the medical department which she has served for more than 25 years.

Dr. Lauretta Bender, professor of clinical psychology, N.Y. University College of Medicine, has been appointed psychiatrist-in-charge of the Infirmary's Child Guidance Clinic. She will inaugurate a consultation service for children and adolescents with behavior problems. The department was established in the Infirmary in 1929. An intensified study of emotional development of children was made in the 1930's. Special workers initiated continuous observations, recorded for future appraisal;

they made pre-natal and post-natal studies, observed child-parent relationships, and evaluated the influence of environment as well as other factors, physical and psychological.

The New England Hospital

Dr. R. Adelaide Draper, chief of the department of general practice at the New England Hospital, has been elected president of the Massachusetts chapter of the Academy of General Practice, the first woman to be so honored in this country.

By means of a bequest, Dr. Bertha Offenbach has undertaken a research project on retrolental fibroplasia. Dr. Offenbach is chief of the department of ophthalmology.

A cardiac research laboratory has been set up under the direction of Dr. Annella Brown, chief of surgery at the New England Hospital; and Dr. Wilfred Neptune, and Dr. Francis Woods of the Overholt Clinic.

A well baby clinic has been established by the Boston Health Department under the leadership of Dr. Clara Waldinger, chief of the pediatric department of the Hospital.

Dr. Felicia A. Banas was recently elected chairman of the active staff of the New England Hospital. Born in Holyoke, Massachusetts, she received her premedical training at Ohio State University, and was graduated from Tufts Medical School in 1926 (cum laude). In 1946, she became a Fellow of the American College of Surgery. Since her internship at NEH, after graduation from Tufts, she has been warmly associated with the hospital. Dr. Banas' husband is an attorney for the Aetna Casualty Company. She has three children, including twins, a boy and a girl.

Other elections at the annual meeting of the medical staff included: Dr. Ann Manton and Dr. Frieda Por, secretary and treasurer respectively. The following were appointed chairmen of staff committees: anesthesia, Dr. Marion Wilkinson; annual report, Dr. Sylvia Ruby; clinical conference, Dr. Jeanne Ward; hospital records, Dr. Dorothy Scheidell; interns, Dr. Ruth Towne; laboratory, Dr. Alice Broadhurst; medications, Dr. Susan Butler; outpatient, Dr. Dorothea Souza; public relations, Dr. Eliza Melkon; staff applications, Dr. Martha Brunner-Orne; and x-ray, Dr. Felicia A. Banas.

Dr. Ruth Towne has resigned as medical director of the outpatient department. Dr. M. Alice Phillips is now acting director of the Hospital.

Dr. Flora Bayan and Dr. Dorothea L. Souza have been awarded scholarships by the Newman Fund Committee to attend the graduate course in pathology given by Dr. Arthur T. Hertig. These awards are from the Helen Worthing Webster scholarship fund.

For the second successive year, the Board of Corporators of Woman's Medical College has given a dinner for the foreign students, interns, and residents at the College. It was held February 25, 1955. This year there were included two men students in the radiology department. Each student present was asked to say why he had come to the College and what he hoped to do afterwards. In the above picture, reading from left to right, are: Dr. Catharine Macfarlane, vice president, Board of Corporators; Donald C. Rubel, president, Board of Corporators; Miss Antonia Carro, Puerto Rico; Miss May Lee, China; Mrs. Nebuwa Nwozo, Nigeria; Dr. Alma C. Corn, Hawaii; Dr. Luz B. Antonio, Philippines; and Miss Sakiko Togashi, Japanese-American.

Woman's Medical College

Founders' Day was celebrated on March 11 with Dr. Connie Guion of New York as guest speaker. Dr. Roberta Hafkesbring, professor of physiology, Dr. Winifred B. Stewart, professor of neurology, and Dr. Charles A. Heiken, clinical assistant professor of medicine, received citations for 25 years of service on the faculty.

Dr. Margaret Castex Sturgis has received for her technical writings a citation from the Philadelphia chapter, National League of American Pen Women. It reads, "In recognition of unselfish and loyal service to humanity as physician, surgeon, teacher, and writer."

A grant for $12,100 from the Life Insurance Medical Research Fund has been made to Dr.

PHYLLIS A. BOTT, professor of physiological chemistry and chairman of the department, "For the study of electrolyte excretion by analysis of samples collected from individual nephrons of the kidneys of small animals." This is a renewal of previous grants.

A grant for $2,987 has been received from the USPHS by DR. MARY PURCELL WIEDEMAN, associate in physiology, to continue her work begun under earlier grants in the study of, "Sensitivity in Denervated Vascular Structures."

General

DR. EUGENIA ROSEMBERG is staff member of the Worcester Foundation for Experimental Biology, and research assistant of the Worcester State Hospital, in Worcester, Massachusetts. She has been invited to Buenos Aires, to give a course on "Actual Problems of Infantile Endocrinology" in the Circulo Universitario of Avellaneda.

Dr. Rosemberg, now living in the United States, was graduated from the Faculty of Medicine of Buenos Aires, Argentina, and worked later at the Pediatric School, founded by Prof. Juan P. Garrahan. As an award for her scientific work, the Society for Pediatric Research gave her a scholarship to improve her knowledge of infantile endocrinology at the service directed by Dr. Lawson Wilkins in Johns Hopkins Hospital. After two years in this center, she moved to Montevideo, Uruguay, where she organized a laboratory of endocrinological research in the School of Medicine of that city.

Twelve scientists have accepted assignments to the new human embryology and development study section announced by the Division of Research Grants of the National Institutes of Health, Bethesda. Among the members of this study section are DR. EDITH POTTER of Chicago Lying-In Hospital, and DR. KATHERINE BAIN of the Children's Bureau, Public Health Service. DR. ELSA ARENT KEILES of the Division of Research grants, National Institutes of Health, is executive secretary.

* * *

The opening of four new medical mission centers in 1954 gives indication of the ever-widening scope of the Medical Mission Sisters. During the past year, African villagers around Techiman decided that they wanted a hospital of their own.

A 30 bed hospital was opened in Thuruthipuram, South India, on October 4, 1954.

The dispensary in Poona will be the missionary community's tenth foundation in India.

Pare-Pare in the Celebes is the location of the new maternity clinic being staffed by the Dutch Medical Mission Sisters.

THESE WERE THE FIRST

DR. MARGUERITE ALICE NORMANDIN, graduate of Tufts College Medical School, Boston, was the first woman of French-Canadian extraction to become a physician in New Hampshire, where she has practiced in Laconia since 1922. In 1952, the citizens of that city presented her with a scroll of honor, and in the square of Laconia the name of her distinguished family is perpetuated.

DR. ELOIZA DIAZ INZUNZA received a medical degree in 1887 from the University of Chile, the first woman to attain this achievement in Latin America. Until her death November 1, 1950, Dr. Inzunza devoted her efforts to the interests of women and children.

DR. MILDRED GREGORY was the first woman to have been made medical director of Babies Hospital –Coit Memorial in Newark, New Jersey. She received her medical degree from the College of Physicians and Surgeons, Columbia University, New York.

DR. ELIZABETH M. HOCKER graduated in 1897 from the Laura Memorial Woman's Medical College of Cincinnati (University of Cincinnati College of Medicine) and was appointed in 1900 as the first physician of the Catholic Visitation Society which she had assisted in organizing the year before. Dr. Hocker served as Army physician-anesthetist during World War I with a hospital unit overseas.

DR. JESSIE WRIGHT of Dayton, Ohio, was instrumental in developing the electronic rocking bed. She is medical director of the D. T. Watson Home for Crippled Children; director of physical medicine and rehabilitation, University of Pittsburgh School of Medicine; and consultant to the Surgeon General, United States Army Air Force. Her special interest is in research in arthritis, cerebral palsy, and poliomyelitis.

—ELIZABETH BASS, M.D.

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EDITORIAL FORECAST

July 1955

The July number of the JOURNAL will be the annual World Health Organization issue, commemorating the formation of this important agency of the United Nations. Articles describing past accomplishments and future plans for the improvement of health of all peoples of the world have been written especially for the JOURNAL by staff members of WHO.

"World Health and World Peace," an editorial by M. G. Candau, M.D., Director-General of WHO.

"Onchocerciasis: A New Field of Activities of WHO," by M. Giaquinto, M.D., L.D.T.M.

"The World Health Organization and Tuberculosis in India," by E. J. T. McWeeney, M.D.

"An Anti-Leprosy Campaign in Burma," by P. H. J. Lampé.

"Auxiliary Health Workers in the Eastern Mediterranean Region," by J. D. Cottrell, D.P.H.

"WHO Publications," by A. Manuila, M.D.

There will be interesting material concerning medical women around the world, and a summary of activities of the World Health Organization in 1954.

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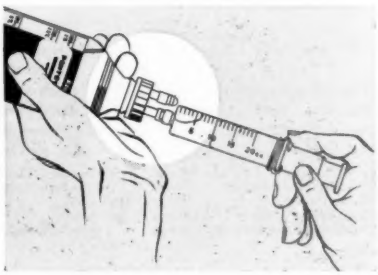

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*Moore, T. D.; and Mayer, R. F.: Hypaque: An Improved Medium for Excretory Urography. A Preliminary Report of 210 Cases. Paper read at 48th Annual Meeting of Southern Medical Assn., St. Louis, Mo., Nov. 10, 1954.

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Pyridoxine-Thiamine *Lederle*

For preventing and treating Hyperemesis Gravidarum

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Each GRAVIDOX tablet contains: Thiamine HCl—20 mg., Pyridoxine HCl—20 mg. Each cc. of GRAVIDOX parenteral solution contains: Thiamine HCl—50 mg., Pyridoxine HCl—50 mg.

Average dose: 5 to 12 tablets daily, in divided doses, at times when vomiting is less likely to occur; or 1 cc. parenteral solution 2 or 3 times weekly.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U. S. PAT. OFF.

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Name..... Address.....
City..... State.....
Single.....Married.....Widow.....Children.....
College..... Graduation year.....
Graduate study..... Further degrees.....
What have you practiced?..... Where?.....
Organizations to which you belong..... Dates.....
Offices held.....
Institutions with which you are, or have been associated.....
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Hospital staff.....
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Date..... GULIELMA FELL ALSOP, *Chairman,* Historical Committee

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for vaginal use

Gantrisin Cream offers a three-fold advantage in the *prophylactic* and *therapeutic* management of *vaginitis, cervicitis, vulvitis and related gynecologic disorders:*

1. wide antibacterial spectrum, plus high solubility, plus low incidence of sensitization.

2. acid pH (4.6) providing unfavorable medium for vaginal pathogens.

3. aesthetic appeal—pleasant white vanishing cream.

Dosage and Administration: from one-half to one applicatorful (2.5-5 cc) introduced into the vagina twice daily (in the morning and upon retiring).

Supplied: 3-oz tubes, with or without applicator.

Caution: If patient develops sensitization, treatment should be discontinued.

GANTRISIN®—brand of sulfisoxazole (3,4-dimethyl-5-sulfanilamido-isoxazole)

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HOPE FOR THE PARAPLEGIC

An industrial rehabilitation department and neurosurgical service for the treatment of paraplegia cases will be established as a first step in the development of a full-scale department of rehabilitation in the Massachusetts Memorial Hospitals and the Boston University School of Medicine. The first such project to be undertaken by a private company, it pioneers a new concept in the handling of those difficult cases paralyzed from injury to the spinal cord and a new philosophy of medical care involving a comprehensive treatment of the patient until he is fully restored to society and back at work. The Liberty Mutual Insurance Company and the Haynes Memorial Department of the Massachusetts Memorial Hospitals are cooperating with the Boston University School of Medicine in this coordinated program of rehabilitation which can markedly reduce disability and permanent impairment in serious injury cases. It will make much-needed hospital facilities available to Boston University for training medical students in this new and specialized field. The Hospital and the University plan to organize a model teaching clinic. The new service will also give Boston a modern rehabilitation facility for the overall care and treatment of neurosurgical patients.

To house the new department, Liberty Mutual will rebuild and re-equip the east wing of Haynes Memorial Hospital to provide a modern unit with beds and all facilities for 26 paraplegia patients, including ambulation and exercise rooms. In addition, an operating room for neurosurgery and a lecture amphitheater for the instruction of medical students will be constructed. Dr. Donald Munro, present Chief of Neurosurgical Services, Boston City Hospital, will head the new department.

The project was started because of the growing need for the coordinated treatment and rehabilitation of spinal cord cases. Before 1940, most cases of separated spinal cords resulted in death. Now, advances in medical knowledge and the development of drugs used in the control of shock and systemic infection account for many survivals. The very earliest possible treatment of the patient, before complications set in, requires constant medical and nursing care for long periods of time, frequently necessitating several different specialists.

Liberty Mutual, which is the nation's leading workmen's compensation carrier, and is confronted with many spinal cord cases, began its rehabilitation service for paraplegia in 1945. The first case took over five years treatment before the patient was able to work. Today the same case would be rehabilitated successfully in one-third the time. The company has already undertaken rehabilitation on sixty-four paraplegia cases and completed work on forty-nine. Of that number twenty-five (51 percent) have returned to work or are in business for themselves. It is pointed out that rehabilitation effects large overall savings in medical and convalescent treatment. Without rehabilitation, the anticipated cost of the forty-nine completed cases would have amounted to approximately $4,894,570. As the result of rehabilitation, the cost of these cases was reduced to $2,654,970, a gross saving of $2,239,600. The cost of providing rehabilitation was $488,654, a net saving through rehabilitation of $1,750,946, not to mention the gain in self-respect which comes to the patient from the return of independent earning power.

Treatment of the paraplegic case starts with neurosurgery, often requires plastic surgery, bone grafting, general surgery and special medical study. It needs the services of not only surgical and medical specialists but urologists, specially trained nurses, physical therapists, vocational training experts and job placement specialists. *There is a serious personnel shortage in all these fields at the present time.*

HEARTBEATS—FROM 12 TO 1300

The rate of the heartbeat among vertebrates varies inversely with the size of the animal or its blood heat. The mouse's pulse beats at a rate of between 620 and 780 per minute, the canary's is roughly 1,000 and the shrewmouse's 1,300,—that is, more than twenty beats per second, because these are all small warm-blooded creatures. On the other hand, the heart of the elephant beats at a rate of 24 to 53 a minute, and that of the white whale from 12 to 35. Among cold-blooded animals, the frog's pulse rate is 30, and the tortoise's between 12 and 20 per minute.

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AT
BREAKFAST?

BONADOXIN*

(BRAND OF MECLIZINE HCL, PYRIDOXINE HCL)

stops morning sickness

RESULTS
of
this
new
COMBINATION

In 100 patients with severe nausea and vomiting, Weinberg reports 88% good to excellent results.[1] In another series, BONADOXIN abolished vomiting in 40 of 41 gravida, eliminated nausea in 30 of the 41.[2]

Each BONADOXIN tablet contains:

MECLIZINE HCl	**25 mg.**
PYRIDOXINE HCl	**50 mg.**

Mild cases: One BONADOXIN tablet at bedtime.
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1. Weinberg, Arthur and Werner, W. E. F.: Bonadoxin, a new effective oral therapy for hyperemesis gravidarum. Am. Pract. and Dig. of Treatment. In press. 2. Personal communication. 3. Berenson, F.: Bonadoxin: oral therapy for nausea and vomiting of pregnancy. In press.

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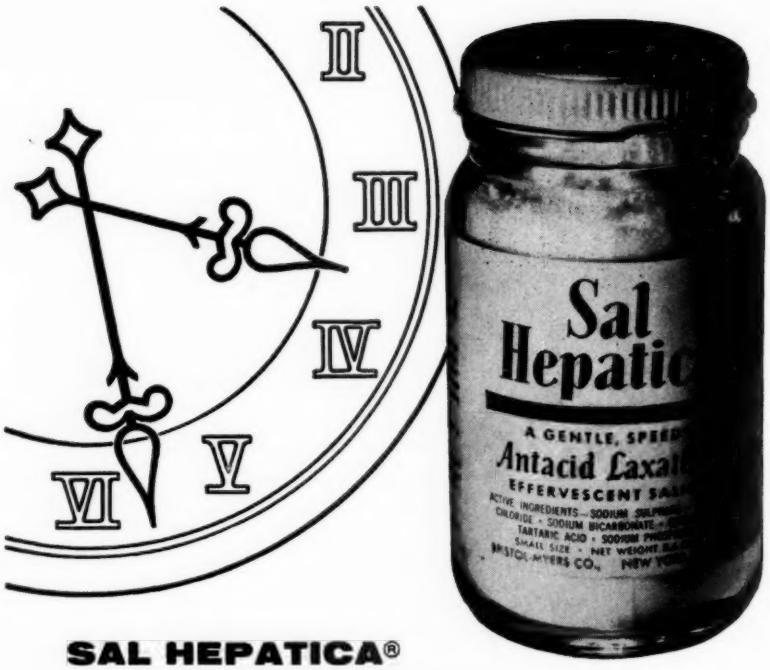


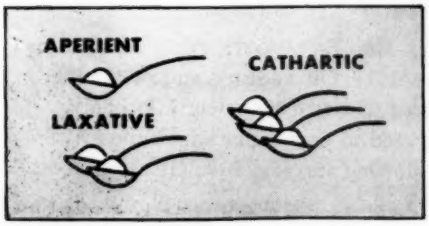
SAL HEPATICA® ACTS SO PROMPTLY BECAUSE...

SAL HEPATICA'S Action Has a Sound Pharmacologic Basis

1. It is antacid and effervescent. Reduction of gastric acidity decreases emptying time of the stomach.[1]

Effervescent mixtures also shorten the emptying time.[2]

Thus SAL HEPATICA quickly leaves the stomach to enter the intestine where its laxative action takes place.



2. It stimulates intestinal peristalsis by its osmotic action. The fluid drawn into the intestine is a mechanical stimulus to evacuation, which usually follows promptly.

Prompt, gentle laxation without griping follows the use of pleasant-tasting SAL HEPATICA. The gastric hyperacidity so frequently accompanying constipation is relieved, too, because SAL HEPATICA is antacid.

References:

1. The Physiological Basis of Medical Practice. 1945. p. 486.
2. New England J. Med. 235:80. July 18, 1946.

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(Continued on page 44)

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125 mg./5 cc. teaspoonful

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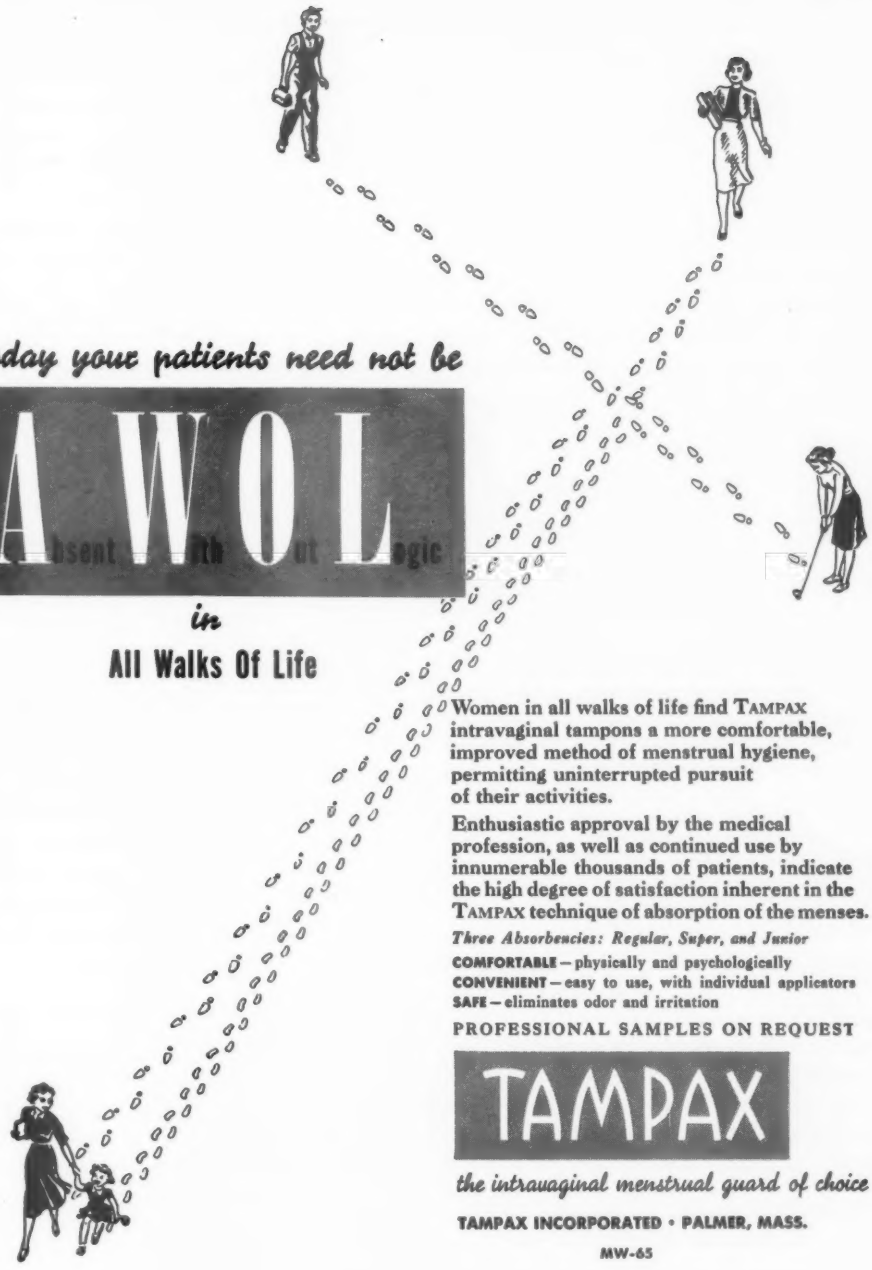

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IT HAS BEEN REPORTED THAT—

Intestinal amebiasis symptoms were eradicated in a series of ten patients by treatment with Erythromycin and Mantomide (Sterling-Winthrop) according to a group headed by Dr. Gordon McHardy of the Browne-McHardy Clinic, New Orleans. No symptoms were observed at the end of a 20 day follow-up period. None of the group exhibited side effects. When the series was subsequently expanded to include 26 patients, with an average follow-up period of 45 days, a recurrence rate of only 3.8 per cent was noted. The ideal combination of drugs to treat the disease, Dr. McHardy states in a report in *Antibiotics Annual* (p. 863, 1955), is a chemical agent, or directly-acting antibiotic without other antibacterial influence, combined with an innocuous, indirectly-acting antibiotic. Mantomide was selected for the combined study because it was 88 per cent effective against intestinal amebiasis when given alone. In these tests it had shown no side effects or indications of toxicity. Unlike most amebicidal drugs, Mantomide contains no iodine or arsenic. Its action is specific, killing the parasites but leaving bacteria found in the intestine relatively unaffected. Mantomide, synthesized at the Sterling-Winthrop Research Institute, is N-(2, 4-dichlorobensyl)-N-(2-hydroxyethyl) dichloroacetamide.

The tremor and limb stiffness of Parkinsonism were noticeably reduced in 13 of 17 patients who were treated with a new drug called Parsidol (Warner-Chilcott) under the direction of Dr. Dewey K. Ziegler and Dr. Fernando Torres at the neuropsychiatric division of Montefiore Hospital, New York. The study started with 30 patients, of whom 13 were eliminated because they reacted either favorably or unfavorably to placebos, which all patients were given first. After these more suggestible patients had been eliminated, Parsidol tablets were substituted for the placebos without the knowledge of the patients or of one of the two physicians. Thus the doctors believe that their study, despite the limited number of cases, represents an objective evaluation of the drug. They report that "subjective response (to Parsidol) proved to be a reliable clue to drug effect, either beneficial or not. It is striking that in 10 of 12 patients reporting subjective improvement, objective improvement was found on examination." Such factors as rigidity, tremor, facial expression and gait were watched by the investigators for signs of improvement. "Parsidol would seem to be a useful addition to the drugs available to patients with Parkinsonism, since 13 of 17 fairly reliable patients showed some degree of improvement in tremor or rigidity or both. It should be emphasized again that the changes are rarely striking and that this medication, like all others used for patients with this condition, is most effective in combination with other drugs. Two patients in this series were treated successfully with Parsidol alone and all others were given Parsidol while their previous medication was continued."

Eradication of pinworms may be accomplished by a seven-day course of treatment with Terramycin,® which is regarded by Dr. Elmer H. Loughlin and Dr. William G. Mullin (New York Medical College and Flower and Fifth Avenue Hospitals) as the most efficient single drug for the purpose. *Antibiotic Medicine* (3:145), carries a report on a test of this broad-spectrum antibiotic on 92 patients with pinworm. Eighty-eight were cleared of the parasite. Although there were instances of reinfection or relapse in some of the "cured" cases, the physicians said that Terramycin therapy is preferred for the eradication of pinworm. It appears to arrest the development of the pinworm and thus prevents reinfection of the patient. Scratching of the irritated perianal area by the patient contributes to reinfection.

The clinicians note a difference in action between Terramycin and the piperazine compounds that are used in the treatment of enterobiasis. On the basis of these apparently different actions, they suggest that a combination of Terramycin and a piperazine compound might be highly effective, and that each also could be given for shorter periods of time. Studies are now being conducted to determine the possibility of the synergistic action of these agents.

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Nasal symptoms—**Corticloron Nasal Spray** by Schering

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Nausea and vomiting — **Thorazine Hydrochloride Syrup** by Smith, Kline & French

Nervous tension

—**Elixophyllin** by Sherman

—**Medomin Tablets** by Geigy

—**Nolular** (non-barbiturate hypnotic) by Hoffmann-La Roche

(Continued on page 49)

Upjohn

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Pamine tablets

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Each tablet contains:
Methscopolamine bromide
2.5 mg.

Average dosage (ulcer):
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Bottles of 100 and 500 tablets.

The Upjohn Company, Kalamazoo, Michigan

Journal of the
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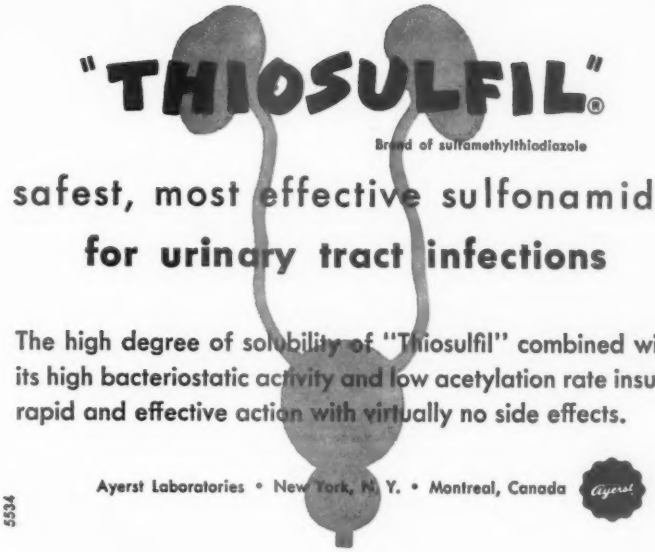
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Digestor for laboratory—**Micro Kjeldahl Digestor** (6-unit) by Laboratory Construction

Fluoroscopic and raediation therapy — **Image Intensifier** by Kay

Hypodermic injections — **Steraject cartridge** (sterile needle attached) 8 dosage forms available by Pfizer

Insulin injection—**Insulin Injector** by Kayden

Liquid diets, to prepare—**Waring Blendor** (gallon-size) by Waring Products

Microscopes—three-dimensional magnification by Bausch & Lomb

Radioactivity, to measure—**Model 181 decade scaler** by Nuclear-Chicago

Radiochromatography — **Actigraph — Model C-100** by Nuclear-Chicato

Tissue grinders—**Potter Elvehjem** by Kontes

Wheel chairs—completely redesigned by Colson

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the right amount of iron
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Elemental Iron..... 210 mg.
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+

Folic Acid	2 mg.
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Liver Fraction 2, N.F.	200 mg.
Thiamine Mononitrate	6 mg.
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Nicotinamide	30 mg.
Pyridoxine Hydrochloride	3 mg.
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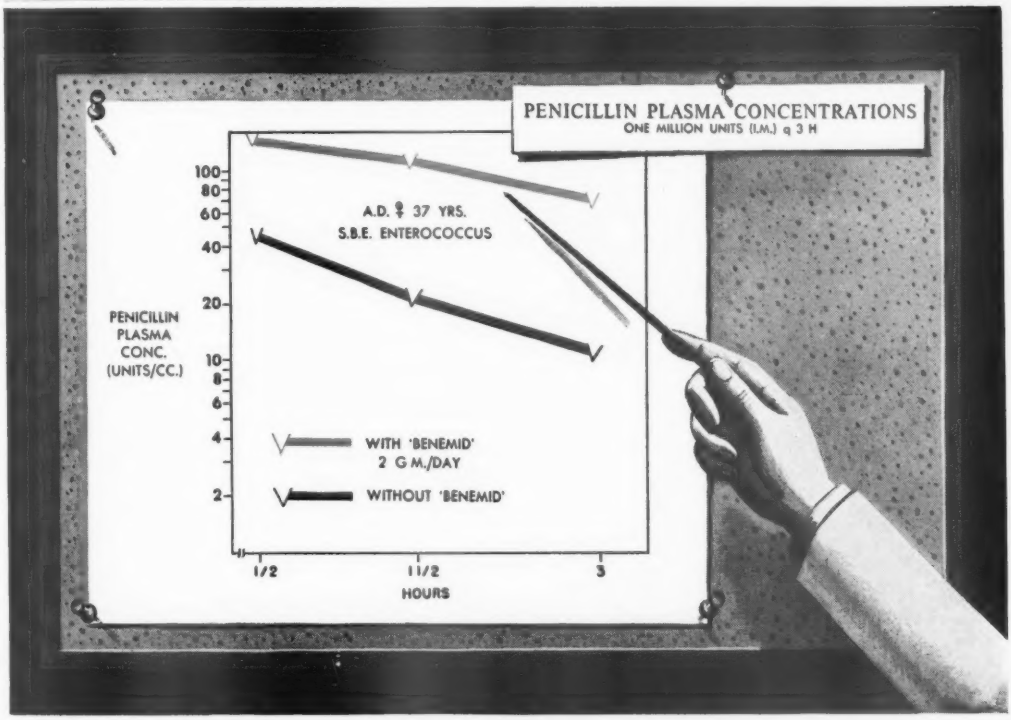
MAJOR ADVANTAGES: Supplements initial intramuscular penicillin. Given alone, produces plasma penicillin levels comparable to those of intramuscular penicillin.[1]



The 'Benemid' in REMANDEN raises plasma penicillin levels[2]

The 'Benemid' component in REMANDEN "increases penicillemia by 2 to 10 times and infections ordinarily regarded as untreatable with penicillin have been successfully managed."[2] With REMANDEN most of the penicillin is recirculated without interfering with normal renal function.

The oral penicillin of choice in many common infections, REMANDEN may be used as adjunct to parenteral therapy of fulminating infections.

Supplied. Tablets, REMANDEN-100 and REMANDEN-250, providing 100,000 or 250,000 units of potassium penicillin G with 250 *mg.* of 'Benemid.'

NEW *Suspension* REMANDEN-100 (in 60 cc. bottles)—one tsp. equals one REMANDEN-100 tablet.

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References: 1. Antibiotics & Chemotherapy 2:555, 1952. 2. A.M.A. Exhibit, June 1951.

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